Ombwdsmon
Ombudsman
Cymru · Wales

Special Report issued under s28 of the Public Services Ombudsman (Wales) Act 2019 following a complaint made against Swansea Bay University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202407678

Contents	Page

Introduction

This report is issued under s.28 of the Public Services Ombudsman (Wales) Act 2019 ("the Act").

We have taken steps to protect the identity of the complainant and others, as far as possible. The names of the complainant and others have been changed.

Summary

Mr W complained to the Ombudsman, in January 2025, about a delay in receiving total knee replacement surgery from Swansea Bay University Health Board, which he said he had been waiting for since August 2019. The investigation considered whether Mr W's waiting time for surgery was appropriately managed in line with the Welsh Government's Rules for Managing Referral to Treatment Waiting times, specifically when his waiting time clock was reset in October 2023.

The Ombudsman upheld Mr W's complaint and found that his waiting time clock had been inappropriately reset in October 2023. On 20 November 2025, a report of the investigation was published in the public interest. The Ombudsman made recommendations that the Health Board agreed to undertake.

The Health Board has failed to complete 2 of the recommendations which were due to be undertaken by 12 February 2026. These recommendations were:

- to complete an independent audit of its orthopaedic waiting list to establish if any other patients had been treated incorrectly in the same way as Mr W, and

- to include this type of scenario in its staff training to ensure its approach to waiting list management was in keeping with the relevant guidance.

The Health Board has not provided the Ombudsman with an expected timeframe to complete these recommendations, so that a suitable extension could be agreed.

The Ombudsman had previously published 3 investigation reports, in January 2024, in relation to how the Health Board had managed its orthopaedic waiting list. These investigations found that all 3 complainants had been treated unfairly because of errors in the way that the waiting lists were managed. As a result of these investigations, the Health Board had agreed to audit its orthopaedic waiting list.

Given that concerns were previously identified in how the Health Board was managing its orthopaedic waiting list, that it had already undertaken an audit of the list, that errors in the management of Mr W's waiting time clock had not been identified in the Health Board's waiting list audit nor during its investigation of his complaint, along with the continuing failure to meet the latest recommendations, without adequate justification, the Ombudsman has used her powers to issue a Special Report. There remain significant concerns about an ongoing risk to patients of their waiting time not being appropriately managed. Therefore, the Ombudsman has made further recommendations for the Health Board to:

Within 4 weeks to:

a) Provide an appropriately amended case study, and evidence of its distribution.

b) Provide the scope of an independent audit, to be agreed by the Ombudsman's office, and a confirmed timeframe for the audit to be undertaken.

c) Present this report to its Board and for the Chair of the Board to provide assurance to the Ombudsman that the Health Board is implementing these recommendations.

Within 12 weeks to:

d) Provide evidence that training has been developed that specifically addresses the failings of Mr W's case and a confirmed timeframe for its implementation.

Within 16 weeks to:

e) Provide the independent audit findings report.

f) Provide evidence that any patients identified as having incorrect waiting time dates have received an apology, their waiting list date corrected and that appropriate action has been taken to address any failings and systemic issues identified during the audit.

g) Provide evidence that the updated training has been implemented.

My jurisdiction

1. Where I am not satisfied that a relevant body has carried out the actions it explicitly agreed to undertake, within the time specified, I may issue a Special Report under S28(6) of the Act.

The background

2. In January **2024**, I published 3 reports[1] in the public interest in relation to Swansea Bay University Health Board's ("the Health Board") management of its waiting list for orthopaedic treatment. These reports found that, in all 3 cases, the complainants had been treated unfairly because of errors in the way the waiting lists for orthopaedic surgery were managed. One of the recommendations contained within the reports was for the Health Board to carry out an audit of its waiting list to establish whether any other errors had been made relating to the setting of waiting list times or improper removal from the waiting list.

3. I received a complaint from Mr W, in January **2025**, about a delay in receiving total knee replacement surgery from the Health Board, which he said he had been waiting for since August 2019. The investigation considered whether Mr W's waiting time for surgery was appropriately managed in line with the Welsh Government's Rules for Managing Referral to Treatment Waiting times ("the RTT guidance"), specifically when his waiting time clock was reset in October 2023.

4. On 25 November I issued a public interest report detailing the findings of my office's investigation. The investigation found that Mr W's waiting time clock was inappropriately reset in October 2023. It found no evidence that a clinician had documented that Mr W was medically unfit to proceed with surgery. Mr W required a repeat scan, due to the amount of time that he had been waiting, which confirmed his fitness to proceed. The decision to reset Mr W's waiting time clock was also not communicated to him. As a result of the delay, Mr W had experienced pain, reduced mobility and ongoing frustration. Further to this, he was now in a position where he was not able to proceed with surgery and the opportunity had been lost.

[1] 202200425, 202201496 and 202200361

5. The investigation report detailed 5 recommendations for the Health Board to undertake. The first 2 recommendations were to be completed within 4 weeks of the report:

a) Arrange for the Chief Executive to make an apology to Mr W for the failings identified in the management of his waiting time for surgery.

b) Share the report with relevant staff and reflect on the failings identified, in particular the need for there to be a well-documented clinical decision before a patient is deemed unfit for surgery.

6. The final 3 recommendations were to be completed within 12 weeks of the report:

c) Appoint an independent person to re-audit its orthopaedic waiting list to establish if any other patients have been treated incorrectly in the same way as Mr W, including incorrect waiting time reset date and/or not being informed of their waiting time clock being reset. If any are identified, the Health Board should apologise to those patients and ensure the correct waiting list date is recorded. The Health Board should propose a scope for the audit that should be agreed by this office before the audit commences ("the Audit recommendation").

d) Given that the Health Board remained of the view, during the course of my investigation, that it was appropriate to reset the clock in Mr W's case, it should ensure its training for staff on the application of the RTT guidance includes this type of scenario, to ensure that its approach to waiting list management is in keeping with the RTT guidance ("the Training recommendation").

e) Share the report with its Board which should nominate a Committee to maintain oversight and monitoring of the Health Board's compliance with these recommendations.

7. The Audit recommendation was specifically to be an independent audit due to concerns about the reliability of the previous audit the Health Board had undertaken, because of the further issues identified in the investigation of Mr W's complaint.

8. Before issuing the report, on 2 October, the Health Board told me that it accepted the report and the recommendations in their entirety.

Implementation of recommendations

9. On 22 December, the Health Board provided evidence that it had complied with the first 2 recommendations.

10. On 12 February **2026** the Health Board provided an action plan of how it was addressing the remaining recommendations. In respect of the Audit recommendation, the Health Board said that it had engaged with an external body to undertake the audit as part of a wider national review. It said it would continue to engage closely with the organisation and would share a scope of the audit once the parameters of the national review were available. It also provided a draft audit scope it had prepared.

11. In respect of the Training recommendation, the Health Board said it was working in collaboration with other bodies to update the relevant training programmes with the aim for a national training programme to be available. It said one particular module, for complex pathways, would fit Mr W's scenario and it would ensure this was discussed when developing the training material.

12. Further information was requested from the Health Board in relation to both of these recommendations on 13 February and 24 February. A reminder was also sent to the Health Board on 4 March and a response received that day. The Health Board said that it was unable to provide evidence of the external body agreeing to do the audit at that time. It also said that it was unable to confirm when the training would be available for staff but anticipated it would be "sometime in the summer".

13. On 23 March I wrote to the Health Board's Chief Executive, expressing my concerns about lack of progress with regards to the Audit and Training recommendations. On 10 April, I met with the Chief Executive and was informed that the external body was no longer able to undertake the audit. However, the Health Board was liaising with NHS Wales Shared Services Partnership Internal Audit ("the Internal Audit Team") and intended to prepare a scope of the work in the coming weeks. It was

agreed that the Health Board would provide my office, by 24 April, with the scope of the audit and expected timeframe for completion, along with evidence that Mr W's scenario had been (or would be) included in the new training programme.

14. On 24 April the Health Board informed my office that the Internal Audit Team had agreed to undertake the audit and expected it to be completed by the end of July. It said the team was currently working on a scope for the audit. In respect of the Training recommendation, the Health Board explained that further meetings had taken place with the relevant external bodies to discuss the training and its timeline, but it was unable to provide a timeline for completion. As an interim measure, the Health Board said it was writing up Mr W's case so that it could be shared with relevant staff for learning, to be distributed by 6 May.

15. On 27 April my office wrote to the Health Board. We asked the Health Board to provide the scope for the audit and an expected date for the Internal Audit Team to complete the work, so that an appropriate extension could be agreed. In respect of the Training recommendation, we agreed that the case study was an appropriate interim measure and requested a copy of this and evidence of its distribution. We also requested that the Health Board provided a reasonable date it expected the training to be ready, so that an extension of the deadline for this recommendation could also be made.

16. On 8 May the Health Board provided a copy of the case study that had been written and evidence of its distribution to relevant staff.

17. On 15 May the Health Board was reminded that it had not provided a response to the other queries raised on 27 April.

18. On 27 May, my office wrote to the Health Board to ask for an amendment to the case study as it did not reflect the investigation finding that Mr W's waiting time clock had been reset despite there being no written evidence that a clinician had determined Mr W to be medically unfit to proceed with surgery.

19. On 18 June, my office wrote to the Health Board again to request a response to the information requested on 27 April and 27 May.

20. On 26 June the Health Board wrote to my office. It said that, although the Internal Audit Team had proposed a scope for the audit, the internal systems did not allow it to extract the data required. Until this was resolved it was unable to agree the scope of the audit or provide a timescale for completion. In respect of the questions about the Training recommendation, the Health Board said 2 other individuals were copied into the correspondence in order to provide an update. No further update was received.

21. On 2 July I wrote to the Health Board to explain my intention of issuing this Special Report due to the ongoing concerns about non-compliance with the Audit and Training recommendations. The Health Board responded to apologise for the delay and requested to meet. We declined a further meeting at that time, given a meeting had already been held with the Chief Executive and we had clearly set out the actions required from the Health Board.

22. On 9 July the Health Board provided a draft audit scope from the Internal Audit Team. It also explained that it would like to meet to discuss the Training recommendation, as it did not agree that the requested change to the case study and training module (in respect of there needing to be clinical documentation that a patient was unfit to proceed with surgery before their waiting time clock was reset) was in line with the RTT guidance. In response, the Health Board was asked to provide a timeframe for the Audit recommendation to be completed, so an extension could be agreed. It was also asked to confirm where in the RTT guidance it stated that a patient's waiting time clock can be reset when there is no documented evidence that a patient had been deemed medically unfit to proceed with a procedure.

23. On 17 July the Health Board provided the final audit scope, which contained reference to the sampling methodology to be agreed with my office prior to the fieldwork being completed. The Health Board also stated that the Internal Audit Team could confirm the date when the Audit recommendation would be met and provided a contact within that team. In respect of the Training recommendation, the Health Board did not respond to the question asked and repeated its request to meet to discuss this.

24. On 20 July the Internal Audit Team wrote to my office. It explained that it was not yet in a position to finalise the sampling methodology nor provide a

definitive date for completion of the audit. It said that it was working with the Health Board to understand the dataset that had been provided and to determine if it could be refined, before proceeding to finalise the sampling approach. It said that it was proactively progressing the work and seeking to complete it as quickly as possible, while ensuring the audit was sufficiently robust to address the Audit recommendation. On 14 August, the Internal Audit Team wrote again to my office to explain that an additional dataset report was required to enable targeted sampling of appropriate cases. In the interim, it was continuing to progress other aspects, such as work relating to policies, procedures, training and governance, whilst the work on the dataset was being finalised.

Comments on the draft report

25. On 13 August the Health Board commented on a draft version of this report. It said that it offered apologies for not providing evidence to satisfy the outstanding recommendations. It said it accepted the content of the report and the further recommendations made.

26. In respect of implementing the appropriate training materials, the Health Board explained that it recognised the need for clear and formal documentation to ensure the decisions regarding a patient's fitness to proceed with surgery were appropriately communicated by medically qualified staff, in line with the RTT guidance. It said it had developed appropriate pathways which included a proforma that clearly identifies where a patient is deemed unfit to proceed with surgery and specifies the appropriate action, such as an adjustment for a defined period to allow fitness to proceed to be established, or whether a patient should be removed from the waiting list and subsequently reinstated once fit to proceed. The Health Board said that revised processes were being embedded and then the training material would be amended.

Analysis and conclusions

27. The Health Board explicitly agreed to accept and implement the recommendations set out in my investigation report and it has failed to do so within the agreed timeframe. Further to this, the Health Board has been unable to provide an expected timeframe for these to be completed so that an extension to the original deadline of 12 February 2026 could be agreed.

28. Despite a number of opportunities, the Health Board has failed to provide any meaningful evidence that the Training recommendation is being progressed or completed. It is only recently that evidence of progression of the Audit recommendation has been provided but it remains that the scope is not finalised and the audit has yet to be commenced.

29. In addition, despite previously confirming that it accepted the investigation findings and recommendations in full, it is apparent that the Health Board changed its view and this has impacted its ability to implement the Training recommendation.

30. Given the 3 previous investigations I published, the previous audit that the Health Board completed which did not identify Mr W's case, along with the findings of the investigation into Mr W's complaint, the lack of progress made to meet the Audit and Training recommendations and the Health Board's changing view in respect of the findings, I am deeply concerned that this means that other patients remain at risk of their waiting time not being managed in line with the relevant guidance. I remain of the view that there needs to be independent scrutiny of the waiting list to ensure that there is written evidence of a clinician determining a patient is unfit for surgery before their waiting time clock is re-set and communication with the patient of this change, along with appropriate training.

31. In view of my persisting concerns as outlined above, and the Health Board's failure to implement the agreed recommendations, I will share this report with the Chair of the Health Board's Board, the Cabinet Minister for Health & Care and with Healthcare Inspectorate Wales.

Further recommendations

32. I expect and recommend that the Health Board should, within 4 weeks of this report:

a) Provide an appropriately amended case study, and evidence of its distribution.

b) Provide the scope of an independent audit, to be agreed by my office, and a confirmed timeframe for the audit to be undertaken.

c) Present this report to its Board and for the Chair of the Board to provide assurance to my office that the Health Board is implementing these recommendations.

33. I expect and recommend that the Health Board should, within **12 weeks** of this report:

d) Provide evidence that training has been developed that specifically addresses the failings of Mr W's case and a confirmed timeframe for its implementation.

34. I expect and recommend that the Health Board should, within **16 weeks** of this report:

e) Provide the independent audit findings report.

f) Provide evidence that any patients identified as having incorrect waiting time dates have received an apology, their waiting list date corrected and that appropriate action has been taken to address any failings and systemic issues identified during the audit.

g) Provide evidence that the updated training has been implemented.

35. I am pleased to note that in commenting on the draft of this report the Health Board has agreed to implement these recommendations.

Michelle Morris

27 August 2026

Michelle Morris
Ombwdsmon Gwasanaethau Cyhoeddus | Public Services Ombudsman

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel: 0300 790 0203
Website: www.ombudsman.wales
Email: ask@ombudsman.wales