Meeting Date	**26 September 2019**	**Agenda Item**	**2.1**
Report Title	Public Service Ombudsman Annual Letter		
Report Author	Hazel Lloyd, Head of Patient Experience, Risk & Legal Services		
Report Sponsor	Gareth Howells, Director of Nursing & Patient Experience		
Presented by	Gareth Howells, Director of Nursing & Patient Experience		
Freedom of Information	Open		
Purpose of the Report	This report updates the Board with the Public Service Ombudsman Annual Letter for the former Abertawe Bro Morgannwg University Health Board for the period 2018/19.		
Key Issues	The Annual Letter highlights: • An increase in the number of complaints referred to the Public Service Ombudsman in 2018/19 (139) compared to 2017/18 (121); • Decrease in the number of complaints which proceeded to investigation 2018/19 (35) when compared to 2017/18 (37). Action being taken to improve and learn from complaints includes: • Concerns Assurance Manager taking a lead in terms of ensuring timely responses are sent to the Ombudsman. • Training programme in place to share the learning from Ombudsman cases and findings following the Concerns, Redress & Assurance Group (CARG) following a review of closed complaint responses.		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐
Recommendations	Members are asked to: • **NOTE** the contents of the report and actions being taken to improve complaint management and learn from the Ombudsman cases.		

PUBLIC SERVICE OMBUDSMAN ANNUAL REPORT

1. INTRODUCTION

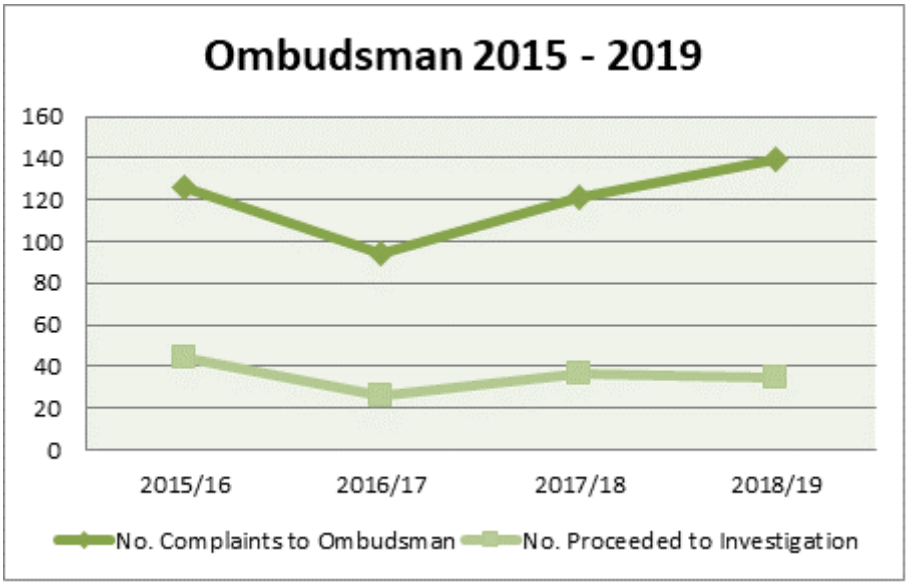
This report provides the Board with the Public Service Ombudsman Annual Report in relation to complaints referred to the Ombudsman during 2018/19.

2. BACKGROUND

The Public Service Ombudsman provides an Annual Letter, attached as **Appendix 1**, to each Health Board in Wales. On this occasion it also contains the Annual Report and Accounts data, which has allowed the Health Board to analyse its performance in comparison with other Health Board's in Wales.

3. GOVERNANCE AND RISK ISSUES

There has been an increase in the number of cases referred to the Ombudsman during the reported period of 2018/19 compared to 2017/18.



	2015/16	2016/17	2017/18	2018/19
No. Complaints to Ombudsman	126	94	121	139
No. Proceeded to Investigation	44	26	37	35

The Health Board monitors the new Ombudsman cases as part of our monthly performance review of data and undertake an analysis of themes and trends. We have noted that complaints handling is a common theme throughout the Health Board, and often the only part of an Ombudsman concern which is upheld when we receive the final Ombudsman report.

There has been a slight decrease of complaints investigated by the Public Services Ombudsman for 2018/19 compared to 2017/18. We remain committed to improving

this trend and review all cases that have been referred to the Ombudsman's Office to learn and improve.

The Health Board has not received any Section 16 Public Services Ombudsman Wales reports within the past 12 months. Compared to 9 Section 16 reports issued to other Health Board's in Wales.

Work to reduce the number of cases which require Ombudsman intervention

A member of staff within the Patient Experience, Risk & Legal Services Department has been provided with dedicated time with responsibility for:

- Investigating Ombudsman cases and complaints;
- Promoting a culture of learning and improvement within the Service Delivery Units; and
- Developing a positive relationship with the Ombudsman's investigators.

As a result all Ombudsman timescales have been met to ensure continued timeliness when communicating with the Ombudsman. Key Performance Indicators are in place and monitored using the Datix system, which assist with achieving the timescales set by the Ombudsman.

We have put in place an Ombudsman Project Plan, which includes a tailored training programme to provide Ombudsman Learning and Assurance training, based on identified themes and trends, to each of the Service Delivery Units. The training will also incorporate the importance of complying with actions agreed at meetings with complainants and in complaint responses. This will ensure a robust system is in place in the Service Delivery Units.

Morriston Hospital Unit received training on 2nd August 2019 and the remaining four Service Delivery Units will receive the training during September 2019, this is being monitored by the Ombudsman Lead and further training provided if indicated by the Units.

On a monthly basis, the Concerns, Redress & Assurance Group (CRAG) review recently closed complaints which includes a 'deep dive' review on each Service Delivery Unit. During this review, any agreed actions by the Service Delivery Units are monitored by the Corporate Complaints Team to confirm actions are completed to ensure compliance. CRAG commenced in 2016 and is continually developing and evolving to ensure that the best possible learning and assurance is attained by the Health Board. We have also introduced CRAG workshops where learning is shared with senior members of all Service Delivery Units.

All complaint responses that are reviewed through the CRAG process are considered in terms of whether the Service Delivery Unit has answered the complaint in full, the handling of the complaint and if it was in accordance with the Regulations. Feedback and support is provided to each Service Delivery Unit through the CRAG process.

Morriston Hospital Service Delivery Unit held a Learning Event on 10th June 2019 which was presented by Dr Mark Ramsey, Unit Medical Director. The event was well

received and continued to promote the Service Delivery Units desire to continually improve and promote the importance of sharing and learning. This also contained a focus on learning from Ombudsman concerns.

Feedback from Patients

The Health Board actively seeks feedback from patients and their families to ensure that we fully capture their experiences of care and are able to assess themes and trends via Friends and Family surveys, Feedback Forms and Patient Experience Digital Stories are all shared with the Service Delivery Units for training purposes and presented at Quality and Safety Group meetings to promote learning from experience of care.

Continue to work with the Improvement Officer to improve complaint handling and the Health Board's response times

The Health Board has a positive relationship with the Ombudsman Improvement Officer. We remain fully committed to continuing the improvements that have been made to date and it is our ambition to no longer require the input of an improvement officer and we view this as an indicator of our focus and commitment to continuous improvement of our concerns management. The Chief Executive also held a reflective discussion session with senior staff from the Units to focus on how we think patients and their families view the way we manage their concerns and how we can improve from this reflection.

The Improvement Officer has also attended and provided training within the Health Board at a Consultant Training Programme on 5th June 2019 and has kindly agreed to attend the December event.

Proposed actions:

- Continue working to the Ombudsman Key Performance Indicators to ensure continued timeliness.
- Tailored Ombudsman training/workshops for each Service Delivery Unit to reduce the number of cases which require Ombudsman intervention.
- Concerns Redress Assurance Group to continue reviewing and auditing complaint responses to ensure compliance with the Regulations.
- Appropriate early resolution to be considered on receipt of each Ombudsman enquiry and investigation.
- Complaints Summit to be held with the Chief Executive on 1st October 2019.
- Health Board Representative attends all Welsh Risk Pool Ombudsman and Complaints Network meetings.

Public Services Ombudsman (Wales) Act 2019

The Public Services Ombudsman (Wales) Act 2019 provided the Ombudsman with powers which will allow:

- Suspected maladministration by a listed authority.
- A suspected failure in a relevant service provided by a listed authority.

- A suspected failure by a listed authority to provide a relevant service.
- Extension to an existing investigation to include consideration of issues other than those complained about.
- Aspects of service or care which were not raised by the complainant.
- Another body which has provided a service or care to the complainant

4. RECOMMENDATION

Members are asked to:

- **NOTE** the contents of the report and actions being taken to improve complaint management and learn from the Ombudsman cases.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☐
	Dignified Care	☐
	Timely Care	☐
	Individual Care	☐
	Staff and Resources	☐
Quality, Safety and Patient Experience		
Taking action to learn from patient experience and complaints aims to reduce the number of incidents/harm to patients in our services.		
Financial Implications		
No financial implications		
Legal Implications (including equality and diversity assessment)		
If complainants are not satisfied with their responses then they may pursue a civil claim.		
Staffing Implications		
No staffing implications.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
No implications.		

Report History	Previous updates have been provided the board.
Appendices	**Appendix 1 Public Service Ombudsman Annual Letter**

Ombudsman Ombwdsmon
PUBLIC SERVICES OMBUDSMAN FOR WALES
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU

Our ref: NB

Ask for: Communications

01656 641150

communications
@ombudsman-wales.org.uk

Date: 7 August 2019

Emma Woollett
Chair of the Board
Swansea Bay University Health Board

By Email Only
emma.woollett@wales.nhs.uk

Dear Ms Woollett

Annual Letter 2018/19

I am pleased to provide you with the Annual letter (2018/19) for Swansea Bay University Health Board. This year I am publishing my Annual Letters as part of my Annual Report and Accounts. I hope the Board finds this helpful and I trust this will enable it to review its own complaint handling performance in the context of other public bodies performing similar functions across Wales.

As you will note from my Annual Report, Swansea Bay UHB (referred to as Abertawe Bro Morgannwg UHB) is one of the four health boards in Wales which has continued to receive the highest number of complaints. Whilst the number of complaints received has increased, the number of complaints investigated by my office has remained consistent. The number of fully investigated complaints which were upheld (in whole or in part) has increased from 15 to 22. I am concerned that the percentage of cases requiring intervention by my office has increased from 27% to 39%. However, I am pleased that following engagement with my Improvement Officer the Health Board has increased the number of cases which were resolved at an early stage. This has been a positive development and I encourage the Health Board to continue its improvement in this area.

As you are aware, as a result of our concerns about the Health Board's ability to meet response timescales set by my office, my Improvement Officer has been working closely with your staff to improve this. I am pleased that some progress

has been made. We will continue to monitor progress in this area this year and I and my staff will continue to provide support and guidance if that would be helpful.

The Public Services Ombudsman (Wales) Act 2019 has now been introduced. I am delighted that the Assembly has approved this legislation giving the office new powers aimed at:

- Improving access to my office
- Providing a seamless mechanism for complaint handling when a patient's NHS care is inextricably linked with private healthcare
- Allowing me to undertake own initiative investigations when required in the public interest
- Ensuring that complaints data from across Wales may be used to drive improvement in public services for citizens in Wales.

I am very much looking forward to implementing these new powers over the coming year.

Action for the Health Board to take:

- Present my Annual Letter to the Board to assist Board Members in their scrutiny of the Board's performance
- Work to reduce the number of cases which require intervention by my office
- Continue to work with my Improvement Officer to improve complaint handling and the Health Board's response times to my office
- Inform me of the outcome of the Health Board's considerations and proposed actions on the above matters by **31 October 2019**.

This correspondence is copied to the Chief Executive of your Health Board and to your Contact Officer. Finally, a copy of all Annual Letters will be published on my website.

Yours sincerely

Nick Bennett
Public Services Ombudsman for Wales

CC: Tracey Myhill, Chief Executive
Susan Ford, Contact Officer

Factsheet

A. Complaints Received and Investigated with Health Board average adjusted for population distribution

Health Board	Complaints Received	Average	Complaints Investigated	Average
Abertawe Bro Morgannwg University Health Board 2018/19	139	132	35	32
Abertawe Bro Morgannwg University Health Board 2017/18	121	127	37	44
Aneurin Bevan University Health Board	134	146	38	36
Betsi Cadwaladr University Health Board	194	173	44	42
Cardiff and Vale University Health Board	102	123	28	30
Cwm Taf University Health Board	75	74	22	18
Hywel Dda University Health Board	109	96	20	23
Powys Teaching Health Board	26	33	3	8

B. Complaints Received by Subject with Health Board average

Abertawe Bro Morgannwg University Health Board	Complaints Received	Average
Health - Complaint Handling	14	12
Health - Appointments/admissions/discharge and transfer procedures	6	4
Health - Clinical treatment in hospital	93	70
Health - Clinical treatment outside hospital	6	8
Health - Confidentiality	1	1
Health - Continuing care	5	4
Health - Other	5	5
Health - Patient list issues	7	3
Adult Social Services – Services for vulnerable adults (e.g. with learning difficulties. or with mental health issues)	1	0

C. Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

Local Health Board/NHS Trust	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution / voluntary settlement	Discontinued	Other Reports - Not Upheld	Other Reports - Upheld in whole or in part	Public Interest Reports	Grand Total
2018/19									
Abertawe Bro Morgannwg University Health Board	26	13	34	32	3	9	22	-	139
Health Board average (adjusted)	21	16	34	26	2	11	26	2	138
2017/18									
Abertawe Bro Morgannwg University Health Board	20	14	33	12	-	7	15	-	101
Health Board average (adjusted)	20	13	30	20	1	9	18	1	111

D. Number of cases with PSOW intervention

Health Board	No. of complaints with PSOW intervention	Total number of closed complaints	% intervention
Abertawe Bro Morgannwg UHB 2018/19	54	139	39%
Abertawe Bro Morgannwg UHB 2017/18	27	101	27%
Aneurin Bevan University Health Board	49	128	38%
Betsi Cadwaladr University Health Board	86	210	41%
Cardiff and Vale University Health Board	37	107	35%
Cwm Taf University Health Board	27	82	33%
Hywel Dda University Health Board	48	115	42%
Powys Teaching Health Board	10	17	59%
Powys Teaching Health Board – All-Wales Continuing Health Care cases	7	16	44%

Appendix

Explanatory Notes

Section A compares the number of complaints against the Health Board which were received and investigated by my office during 2018/19, with the Health Board average (adjusted for population distribution) during the same period.

Section B provides a breakdown of the number of complaints about the Health Board which were received by my office during 2018/19 with the Health Board average for the same period. The figures are broken down into subject categories.

Section C compares the complaint outcomes for the Health Board during 2018/19, with the average outcome (adjusted for population distribution) during the same period. Public Interest reports issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 are recorded as 'Section 16'.

Section D provides the numbers and percentages of cases received by my office in which an intervention has occurred. This includes all upheld complaints, early resolutions and voluntary settlements.

Feedback

We welcome your feedback on the enclosed information, including suggestions for any information to be enclosed in future annual summaries. Any feedback or queries should be sent via email to communications@ombudsman-wales.org.uk