Meeting Date	**27 September 2022**	**Agenda Item**	**6.1**
Report Title	**Public Service Ombudsman Annual Letter**		
Report Author	Erica Thomas Howells, Concerns Assurance Manager & Ombudsman Lead		
Report Sponsor	Gareth Howells, Executive Director of Nursing		
Presented by	Gareth Howells, Executive Director of Nursing		
Freedom of Information	Open		
Purpose of the Report	This report updates the members with the Public Service Ombudsman Annual Letter for Swansea Bay University Health Board for the period 2021/22.		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval that Annual Letter Report & actions from this have been presented to Board**
	☒	☐	☐	☒

Recommendations	Committee members are recommended to: • **NOTE** monitoring system in place to ensure all Ombudsman timescales are met • **NOTE** communication training delivered in 2020/21 and continued to be delivered by the Ombudsman Trainer in 2021/22 • **NOTE** ongoing learning and assurance training with regards to Ombudsman themes by Concerns Assurance Manager • **NOTE** the highest complaints made to the Ombudsman relate to clinical treatment in hospital. The learning from these cases will be presented to Patient Safety Congress in October 2022 and shared Health Board wide by Concerns Assurance Manager • **NOTE** the Health Board has not received any Public Interest Reports this annum, but will be extracting learning from other Health Board's to ensure shared learning and assurance • **NOTE** continue to ensure that early resolutions continue to be undertaken to prevent proceeding to full investigations

PRECIS TO ANNUAL LETTER

- Increase in the number of cases referred to the Ombudsman during the reported period of 2021/22 (110) compared to 2020/21 (79)

- Decrease in the number of complaints which proceeded to investigation from 2020/21 (25) when compared to 2021/22 (17) with 29 Ombudsman interventions overall

- Complaints have increased on an All-Wales basis, only 28% of complaints received by the Ombudsman regarding Swansea Bay required Ombudsman intervention

- Decrease in complaints regarding clinical treatment in hospital (2021/22 53 complaints - 49%) compared to 2020/21 (54 complaints - 67%)

- Increase in the amount of complaints received regarding complaint handling, 5 complaints - 6% in 2020/21, compared to 20 complaints - 18% in 2021/22. Service Delivery Groups have advised this is due to the effects of the pandemic and availability of staff to respond to complaints due to the unprecedented pressures. We will continue to provide support to the Service Delivery Groups during these difficult times to ensure that improvements in relation to complaints handling are made.

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 in terms of investigations and Ombudsman queries – this is considered on receipt of each investigation

- Quarterly Ombudsman Learning Brief's completed by Concerns Assurance Manager and Complaints Support Manager and disseminated on a quarterly basis to ensure ongoing shared learning, development and assurance

- Twice per month Communication Training continues to be delivered by the Ombudsman Trainer twice monthly throughout all Service Groups and specialities with extremely positive feedback from staff – this is arranged corporately by the Complaints Support Manager

Public Service Ombudsman Annual Report

1. INTRODUCTION

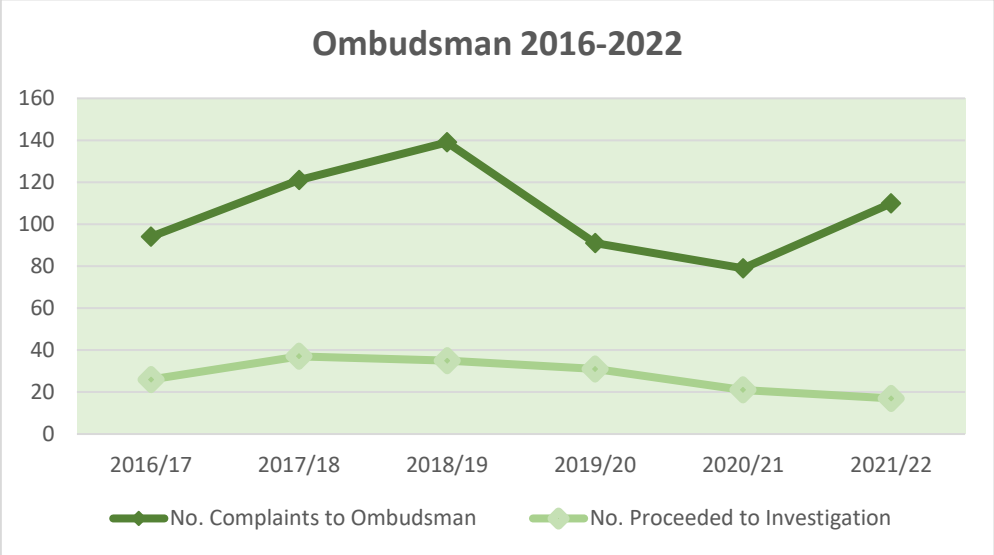
This report provides the Committee with the Public Service Ombudsman Annual Report in relation to complaints referred to the Ombudsman during 2021/22.

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 2021/22 compared to 2020/21



	2017/18	2018/19	2019/20	2020/21	2021/22
No. Complaints to Ombudsman	121	139	91	79	110
No. Proceeded to Investigation	37	35	31	21	17

4. Public Service Ombudsman's Annual Letter

The Ombudsman Annual Letter was received on 9th August 2022, the first from the newly appointed Ombudsman, Mrs Michelle Morris. The Annual Letter advises that the Ombudsman is aware that Health Boards are still experiencing the effects of the pandemic. Last year the number of complaints referred to the Ombudsman regarding Health Boards increased by 30% (compared to 2020/21 figures) and are now well above pre-pandemic levels. It is likely that complaints to the Ombudsman, and public services in general, were suppressed during the pandemic, and we are now experiencing a 'rebound' effect.

During the last financial year, the Ombudsman has intervened in (upheld, settled or resolved at an early stage) a similar proportion of complaints about public bodies, 18% (20% in 2020/21), when compared with recent years. Intervention rates (where the Ombudsman has investigated complaints) for Health Boards also remained at a similar level – 30% compared to 33% in 2020/21.

Swansea Bay had a 28% Ombudsman intervention rate, which is below the average Ombudsman intervention rate on an All-Wales basis

Cases with Ombudsman Interventions

	No. of Interventions	No. of Closures	% Of Interventions
Aneurin Bevan University Health Board	42	125	34%
Betsi Cadwaladr University Health Board	61	193	32%
Cardiff and Vale University Health Board	18	81	22%
Cwm Taf Morgannwg University Health Board	30	99	30%
Hywel Dda University Health Board	23	82	28%
Powys Teaching Health Board	3	6	50%
Swansea Bay University Health Board	29	105	28%
Total	**206**	**691**	30%

The Ombudsman advised that it will be liaising closely with Health Boards, Welsh Government and the Community Health Councils to monitor likely caseloads over the coming year, including in relation to any cases of Nosocomial transmission of Covid which may reach the Ombudsman's Office after the Board's local investigations under the national framework have been completed.

The Ombudsman has thanked the Health Board for the positive way that it has engaged with the Ombudsman's Office during what has been a challenging year for everyone. The Ombudsman very much looks forward to continuing this work and collaboration to ensure the further improvement of public services across Wales.

The Health Board no longer has an Ombudsman Improvement Officer as this was dissolved in July 2022.

5. Ombudsman Process

We monitor 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 the top 3 themes are:

- Clinical Treatment in Hospital (49%)
- Communication and complaints handling is a common theme throughout the Health Board, and often the only part(s) of an Ombudsman concern which is upheld when we receive the final Ombudsman report (18%)
- Mental Health (7%)

Learning and Assurance from the above 3 themes will be presented at the Patient Safety Congress on 6th October 2022

The Ombudsman has delivered monthly Communication Training to all Units and specialities and we have been advised that staff have already seen great benefits from this work, including the standardisation of complaints data recording. The delivery of Communication Training delivered by the Ombudsman continues to be delivered in this financial year also.

6. Public Interest Reports (Section 16)

- An Ombudsman 'Public Interest Report' is a report which has concluded that there has been serious service failure/maladministration by a Public Body.
- The Health Board has to publish a notification within the local media advising of the failure and copies of the report must be available within Headquarters for review by the public, and if requested, a copy provided by the Health Board.
- The Health Board must also ensure a copy of the report is available on our website for public scrutiny.
- The recommendations of a Public Interest Report must be undertaken and fully fulfilled to ensure the incident does not occur again.

The Health Board has not received a Section 16 Public Services Ombudsman for Wales Report during the year 2021/22.

7. Current position

Between the 1st April 2021 to 31st March 2022 the Health Board received 17 new Ombudsman investigations compared to 21 for the same period in 2020/21.

As of the 1st September 2022, there are currently 38 open Ombudsman cases:

Service Delivery Unit	No of Ombudsman Cases Currently open
Morriston Hospital	17
Primary Care & Community **(these 4 are not current Health Board investigations as they involve 3 GP Practices and 1 Dental which the Health Board oversees)**	4
Singleton NPT Service Group	13
Mental Health & Learning Disabilities	4
Total	**38**

Of these 38 cases:

- 3 new investigations
- 25 awaiting the outcome of the Ombudsman's investigation
- 2 investigations are at draft reporting stage
- 7 at formal reporting stage with actions for implementation
- 1 cases awaiting confirmation of compliance

8. Work to reduce the number of cases which require Ombudsman intervention

The Health Board's Concerns Assurance Manager is a dedicated full time lead resource with responsibility for Ombudsman cases and complaints, as well as ensuring a culture of learning and improvement is conveyed throughout the Service Delivery Units within the Health Board. The Concerns Assurance Manager has ensured that all Ombudsman timescales are met to ensure continued timeliness when communicating with the Ombudsman. The Health Board has Key Performance Indictors in place, which are monitored on the Datix system, which assist with achieving the timescales set by the Ombudsman. The Health Board is pleased to be successfully responding to the Ombudsman within the prescribed timescales and very rarely requiring extensions. If an extension is required, usually due to clinicians being on leave or to request an extra day for sign off due to the unavailability of the Executive Team for signing, we liaise closely with the Ombudsman handler to agree.

The Concerns Assurance Manager has 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.

Working on Upheld and Partially Upheld Complaints
Tailored training has been delivered in recognition of a complaints being Upheld and Partially Upheld. A current theme which was assessed was the upholding of complaints regarding both communication and Human Rights.

In light of this, the following training has been delivered:

- Human Rights Training delivered by British Institute of Human Rights
- Breaking Bad News Training delivered by the Christie
- Communication Training delivered by the Ombudsman

9. Concerns Redress Assurance Group (CRAG)

On a monthly basis, the Health Board conducts a Concerns Redress Assurance Group (CRAG) where the Corporate Complaints Team review recently closed complaints. Each month a 'deep dive' review is undertaken on each Service Delivery Group in turn, as well as the review of a selection of closed complaints from the other Service Delivery Group. During this review, any agreed actions by the Service Delivery Group 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. The Health Board has also introduced CRAG workshops where learning is shared with senior members of the Service Delivery Units. All complaint responses that are reviewed through the CRAG process are considered in terms of whether the Service Delivery Group 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 Group through the CRAG process.

The CRAG reviews have identified the following themes from a review of complaints:

- Communication
- Poor Concerns Handling/ Delays/Communication
- Clinical Treatment
- Pain Management
- Poor Record Keeping
- RTT
- Consent

10. Patient Experience and Feedback

We continue to actively seek 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 which are all shared with the Service Delivery Units, used for training purposes and presented at Quality and Safety Group meetings.

11. Persistent / Vexatious Complainants

The Health Board currently deals with high-risk, often persistent and vexatious complainants corporately to assist the Units. If a complainant has their concerns considered by the Ombudsman, complainants, who tend to send vast amounts of communications to the Health Board, often copy the Ombudsman into the emails and letters. We then provide updates to the Ombudsman regarding progress of these cases for them to remain fully informed of the Health Board's management.

12. Continue to work with the Ombudsman Complaints Standards staff to improve complaint handling and the Health Board's response times

The Health Board has worked closely with the Ombudsman's Complaints Standards staff and Ombudsman Trainer in the past 12 months.

We are working closely with the Ombudsman Office to ensure we are compliant and timely with all requests and timescales.

13. Early Resolution

The Health Board is keen to ensure that enquiries and new referrals received from the Ombudsman are considered for early resolution as this is a means of bringing cases to positive fruition by providing the Complainant with a swift and appropriate outcome. One of the functions of the dedicated Concerns Assurance Manager is to review each enquiry and new referral on receipt to evaluate whether it is appropriate for it to be dealt with via early resolution. We have a positive rapport with each of the Service Delivery Units, which assists with clear and timely communication regarding cases suitable for early resolution.

We have had success with early resolutions in the form of:

- Meetings between the Complainant & Specialty.
- Re-opening concerns for investigation.
- Making offers under Redress.
- Ex-gratia payments for poor concerns handling.

Early resolutions preclude the requirement for a full Ombudsman investigation, so are a positive outcome for the patient, Ombudsman and the Health Board.

Early resolutions have increased from 10% in 2020/21 to 16% in 2021/22.

14. Proposed Actions:

Action	Responsibility	Due date
Swansea Bay has been asked to work with the Ombudsman on an agreed recommendations project where the Health Board will work closely with the Ombudsman at the Draft Report stage so that the Health Board has increased involvement in shaping the recommendations and agreeing what good compliance and effectiveness will look like.	Concerns Assurance Manager	Due to commence early 2023
Continuation of ongoing work in relation to Ombudsman Key Performance Indicators to ensure continued timeliness.	Concerns Assurance Manager & Complaints Support Manager	Quarterly
Complaints Standards Training & Communication Training to continue to be rolled out within the Units	Complaints Support Manager	Twice monthly each month
Concerns Redress Assurance Group to continue reviewing and auditing complaint responses to ensure compliance with the Regulations by Assistant Head of Patient Experience, Risk & Legal Services and the Concerns Assurance Manager.	Concerns Assurance Manager Complaints Support Manager	Monthly
Appropriate early resolution to be considered on receipt of each Ombudsman enquiry and investigation	Concerns Assurance Manager	On receipt of each case
Attendance at all Welsh Risk Pool Ombudsman & Complaints Networks	Concerns Assurance Manager Complaints Support Manager	Bi-monthly

Work currently being undertaken in relation to how to provide training to the Units based on the outcomes and learning of the Public Interests (Section 16) Reports received on an All-Wales basis.	Concerns Assurance Manager	Ongoing
Complaints & Ombudsman Newsletter to be published on the intranet each quarter.	Concerns Assurance Manager Complaints Support Manager	Quarterly
Quarterly Learning Brief to be completed with updates in relation to the above ongoing actions.	Concerns Assurance Manager Complaints Support Manager	Quarterly

15. RECOMMENDATION

Committee members are recommended to:

- **NOTE** monitoring system in place to ensure all Ombudsman timescales are met
- **NOTE** communication training delivered in 2020/21 and continued to be delivered by the Ombudsman Trainer in 2021/22
- **NOTE** ongoing learning and assurance training with regards to Ombudsman themes
- **NOTE** the highest complaints made to the Ombudsman relate to clinical treatment in hospital and that the learning from these cases will be presented to Patient Safety Congress in October 2022 and shared Health Board wide
- **NOTE** the Health Board has not received any Public Interest Reports this annum, but will be extracting learning from other Health Board's to ensure shared learning and assurance
- **NOTE** continue to ensure that early resolutions continue to be undertaken to prevent proceeding to full investigations

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**