Meeting Date	**22 September 2020**	**Agenda Item**	**4.2**
Report Title	**Public Service Ombudsman Annual Letter**		
Report Author	Erica Thomas Howells, Ombudsman Lead		
Report Sponsor	Christine Williams, Interim Director of Nursing & Patient Experience		
Presented by	Christine Williams, Interim 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 2019/20.		
Key Issues	The Annual Letter highlights: • A decrease in the number of complaints referred to the Public Service Ombudsman in 2018/19 (139) compared to 2019/20 (91) • A decrease in the number of complaints which proceeded to investigation 2018/19 (35) when compared to 2019/20 (30) 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	The Board is recommended 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

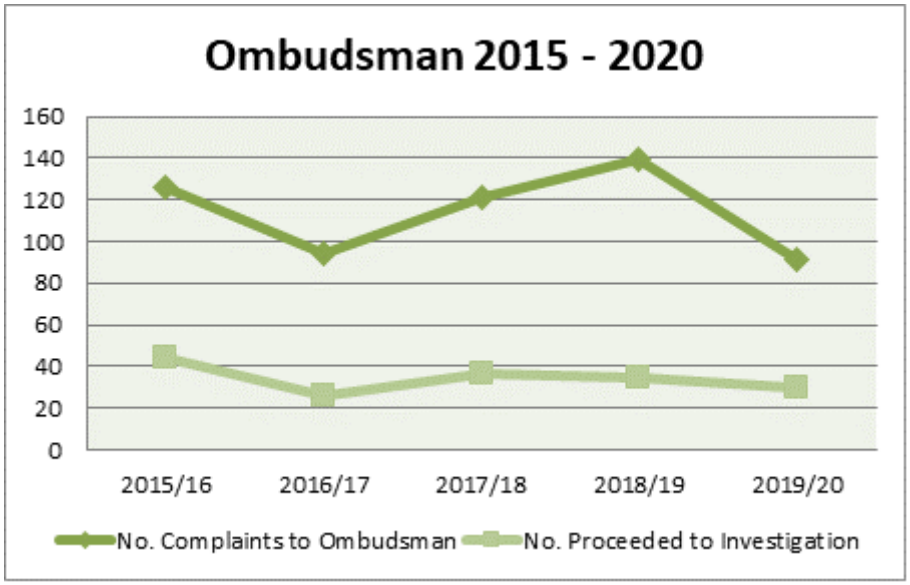
This report provides the Board with the Public Service Ombudsman Annual Report in relation to complaints referred to the Ombudsman during 2019/20.

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 a decrease in the number of cases referred to the Ombudsman during the reported period of 2019/20 compared to 2018/19.



	2015/16	2016/17	2017/18	2018/19	2019/20
No. Complaints to Ombudsman	126	94	121	139	91
No. Proceeded to Investigation	44	26	37	35	30

4. Public Service Ombudsman's Annual Letter

The Ombudsman Annual Letter was received on 8th September 2020 and advises that this is an unprecedented time for public services in Wales. The majority of data contained in the Annual Report relates to the period before the rapid escalation in Covid-19 and before restrictions on economic and social activity had been introduced. The Ombudsman acknowledges that he is only too aware of the impact the pandemic continues to have. The Ombudsman is grateful for Swansea Bay continuing to pro-

actively engage with the Health Board's Ombudsman Improvement Officer and advised he is encouraged by the positive manner with which the Health Board has embraced his input, including via regular invitations to training sessions which enable direct engagement with frontline clinical and nursing staff. In the light of the recent internal reorganisation in the Health Board's complaints handling and governance teams and lead, he trusts that this constructive approach will continue.

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 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.

During the past financial year, the Ombudsman has had to intervene in (uphold, settle or resolve early) a smaller proportion of complaints about public bodies in Wales: 20% compared to 24% last year.

There has been a decrease of complaints investigated by the Public Services Ombudsman for 2019/20 compared to 2018/19. We remain committed to improving this trend and review all cases that have been referred to the Ombudsman's Office to learn and improve.

Complaints about NHS bodies related predominantly to health (88%). However, as in previous years, a significant proportion of these complaints related to complaint handling (8%). The Ombudsman will continue to work with NHS bodies on reducing the number of these complaints, including as part of their new Complaints Standards role.

Work has already started as part of the Ombudsman Complaints Standards role for Wales, so far predominantly with Local Authorities. The Ombudsman has advised that they have already seen great benefits from this work, including the standardisation of complaints data recording. The Ombudsman has advised that they look forward to working more closely with Swansea Bay in the coming months to help embed the new 'Once for Wales' system and, for the first time in Wales, provide complaints handling training to Health Boards, free of charge.

6. Public Interest Reports (Section 16)

The Health Board has received a Section 16 Public Services Ombudsman for Wales Report within the past 12 months.

Morriston & Singleton Hospital - On 5th February 2020, the Health Board received a Public Interest (Section 16) Report from the Ombudsman relating to the case of an 87-year-old patient, who died after Swansea Bay failed to take prompt and appropriate action to assess and treat her symptoms of a stroke. The Ombudsman found that the

Health Board failed to undertake an appropriate assessment of the patient's risk of a stroke, even when her family raised concerns that she appeared to have left-sided weakness, facial droop and slurred speech. It was also found that, when doctors were asked to review the patient's condition, in light of her family's concerns, several clinicians failed to appropriately record their findings. Finally, the Ombudsman found that there were further shortcomings in record keeping throughout the period of care, with particular emphasis on Nutrition.

Themes:

- Stroke Symptoms not acted upon with urgency
- Poor Documentation, Fluid & Nutrition & Referral to Dietician
- Symptom investigation & failure to reconsider whether to pursue an X-ray
- Sedation, Anxiety & Psychiatric Referral
- The patient's human rights were breached

The Ombudsman has advised that they issued a Section 16 Report in this matter due to:

- Wider lessons for all health boards across Wales to learn from this case.
- Failures by 2 separate clinicians to record the key consultations.
- Concerned this might indicate a systemic failure within the Health Board and that the lack of recording has left the family with the uncertainty of not knowing whether the clinical outcome might have been improved, which is a serious injustice to them.
- Ombudsman struck by the Complainant's comment that the Health Board should have listened to family members, who knew the patient better than hospital staff.
- Opportunities were lost by the Health Board to act upon the family's concerns in a timely manner.
- The Ombudsman advised that they have reported on failures of this kind by this Health Board in the past. *When request which case this referred to the Ombudsman advised it was a reference to the Paul Ridd case.*

6. Current position

Between the 1st April 2020 and the 31st July 2020 the Health Board received 3 new Ombudsman investigations compared to 11 for the same period in 2019. The decrease in new investigations received throughout these months could be a result of COVID,

as the Ombudsman minimised the amount of new enquiries and investigations sent to the Health Board during this difficult time.

As of the 24th August 2020, there are currently 35 open Ombudsman cases:

Service Delivery Unit	No of Ombudsman Cases Currently open
Morriston Hospital	17
Primary Care & Community	7
Singleton Hospital	5
Princess of Wales	1
Mental Health & Learning Disabilities	3
Neath Port Talbot	2
Total	**35**

Of these 35 cases:

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

7. 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.

8. Working on Upheld and Partially Upheld Complaints

The Ombudsman Improvement Officer has advised that the Health Board has a high amount of complaints which are upheld and partially upheld. The Concerns Assurance Manager is currently compiling training for the Units on the themes and trends identified by the upheld portions of complaints. Complaints can be solely upheld on complaints handling issues and we are working closely with the Units to provide advice and support regarding this. Tailored training will also be delivered to the Governance and Quality & Safety Teams.

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 Unit in turn, as well as the review of a selection of closed complaints from the other Service Delivery Units. 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. 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 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.

The CRAG reviews have indicated:

- Communication
- Poor Concerns Handling/ Delays/Communication
- Pain Management
- Poor Record Keeping
- RTT
- Consent
- Discharge Planning

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

The Health Board has worked closely with the Improvement Officer in the past 12 months. Steve Brisley, Improvement Officer, has also attended and provided training within the Health Board and at the Consultant Training Programme.

We still currently have our Improvement Officer in place, although 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. Steve Brisley has advised that the amount of early resolutions within the last year has increased, which is a positive outcome.

14. 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.
- Concerns Assurance Manager attends all Welsh Risk Pool Ombudsman and Complaints Network meetings.
- Concerns Assurance Manager works closely with Primary and Community Care Service Delivery Unit to ensure consistency in the approach to cases which relate to the primary care setting.
- Tailored Mental Health & Learning Disabilities training is currently being arranged to reinforce the Putting Things Right Regulations and Redress process.
- Work currently being undertaken on how to provide training to the Units based on the outcomes and learning of the Public Interests (Section 16) Reports received by the Health Board.

15. Public Services Ombudsman (Wales) Act 2019

The Public Services Ombudsman (Wales) Act 2019 is an extremely positive development, which will ensure that complainants are able to directly access the Ombudsman, and therefore the Health Board, which will improve the quality of feedback we receive from patients and promote positive learning and assurance. The Ombudsman's new powers to also investigate private healthcare will now allow a fluid investigation, particularly when patients' paths cross through both NHS and private healthcare. The Ombudsman's Annual Letter advised that they will ensure that complaints data from across Wales will be used to drive improvement for Welsh Citizens accessing Public Services, which as an organisation with an ethos of learning and continual improvement, is a most welcome and exciting development.

16. Ombudsman recent updates:

- Complaints Standards training is being rolled out to Local Authorities via Zoom and MS Teams in September and October. This will be offered to all Health Boards from approximately November time.

- The Ombudsman Investigation Team are now moving back to a more 'business as usual' footing. This means that they won't be contacting Health Boards prior

to an investigation start as they have been since March. Investigators will use their discretion and still call prior to an investigation start where the subject may be more problematic than usual. The Ombudsman have advised that they still wish to maintain a supportive stance to Public Bodies during this time, and have confirmed that they will revise their stance should things get worse in the coming months.

- The Complaint Assessment Team is now able to take complaints from the public over the phone since the introduction of the new Public Services Ombudsman (Wales) Act 2019. The Model Complaints Handling procedure is due to be published later this year and will hopefully mean their services are more accessible to complainants.

- As advised previously, the Ombudsman's powers have recently been extended. In-light of the Ombudsman encouraging patients to raise concerns, they have introduced a Complaint Assessment Team. On 26th August 2020, the Health Board received revised Ombudsman template paragraphs to close our complaint responses, further emphasise the ability of their office to receive complaints over the phone, which has been shared with the Units.

17. RECOMMENDATION

The Board is recommended to:

- **NOTE** the contents of the report.

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** **Appendix 2 Action Plan**