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Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board



Meeting Date	29 September 2022	Agenda Item	4.2
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 Board 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
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Approval that Annual Letter Report & actions from this have been presented to Board		
	<input checked="" type="checkbox"/>		
Recommendations	<p>The Board is recommended to:</p> <ul style="list-style-type: none"> • 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

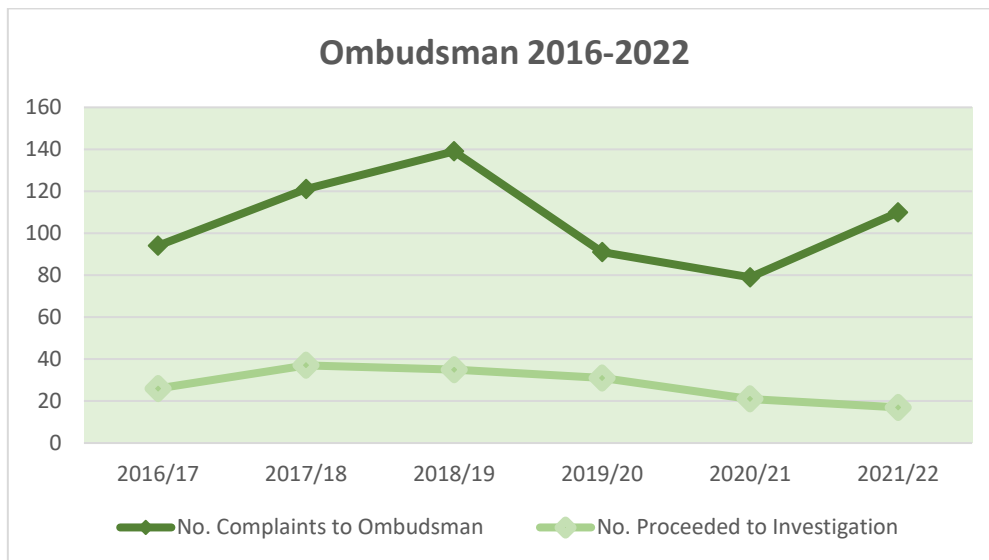
This report provides the Board with the Public Service Ombudsman Annual Report in relation to complaints referred to the Ombudsman during 2021/22.

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
Morrison 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 Indicators 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 & 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

The Board is 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 <i>(please choose)</i>	Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities	
	Partnerships for Improving Health and Wellbeing	<input checked="" type="checkbox"/>
	Co-Production and Health Literacy	<input type="checkbox"/>
	Digitally Enabled Health and Wellbeing	<input type="checkbox"/>
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	<input checked="" type="checkbox"/>
	Partnerships for Care	<input type="checkbox"/>
	Excellent Staff	<input type="checkbox"/>
	Digitally Enabled Care	<input type="checkbox"/>
	Outstanding Research, Innovation, Education and Learning	<input type="checkbox"/>
Health and Care Standards		
<i>(please choose)</i>	Staying Healthy	<input type="checkbox"/>
	Safe Care	<input checked="" type="checkbox"/>
	Effective Care	<input type="checkbox"/>
	Dignified Care	<input type="checkbox"/>
	Timely Care	<input type="checkbox"/>
	Individual Care	<input type="checkbox"/>
	Staff and Resources	<input type="checkbox"/>
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	

Ask for: Communications

 01656 641150

Date: August 2022

 communications@ombudsman.wales

Emma Woollett
Swansea Bay University Health Board

By Email only: Emma.Woollett@wales.nhs.uk

Annual Letter 2021/22

Dear Emma

I am pleased to provide you with the Annual letter (2021/22) for Swansea Bay University Health Board which deals with complaints relating to maladministration and service failure and the actions being taken to improve public services

This is my first annual letter since taking up the role of Public Services Ombudsman in April 2022, and I appreciate that the effects of the pandemic are still being felt by all public bodies in Wales. Our office has not been immune from this, with records numbers of cases being referred to us over the last two years. The strong working relationships between my Office and Health Boards continues to deliver improvements in how we are dealing with complaints and ensuring that, when things go wrong, we are learning from that and building stronger public services.

Complaints relating to Maladministration & Service Failure

Last year the number of complaints referred to us regarding health boards increased by 30% (compared to 20/21 figures) and are now well above pre-pandemic levels. It is likely that complaints to my office, and public services in general, were suppressed during the pandemic, and we are now starting to see the expected 'rebound' effect.

During this period, we intervened in (upheld, settled or resolved at an early stage) a similar proportion of complaints about public bodies, 18%, when compared with recent years. Intervention rates (where we have investigated complaints) for health boards also remained at a similar level – 30% compared to 33% in recent years.

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We 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 my office after the Board's local investigations under the national framework have been completed.

Supporting improvement of public services

Improvement Work

The Public Services Ombudsman (Wales) Act 2019 formalised our work with public bodies to improve complaints handling and learning from complaints. This work has now been consolidated within our Improvement Team who are engaging with a wide range of organisations to support better complaints handling in public bodies.

Proactive Powers

In addition to managing record levels of complaints, we also continued our work using our proactive powers in the Public Services Ombudsman (Wales) Act 2019. Specifically undertaking our first Own Initiative Investigation and continuing our work on the Complaints Standards Authority.

October 2021 saw the publication of the first own initiative investigation in Wales: [Homelessness Reviewed](#). The investigation featured three Local Authorities and sought to scrutinise the way Homelessness assessments were conducted. The report made specific recommendations to the investigated authorities, as well as suggestions to all other Local Authorities in Wales and Welsh Government. Some of these recommendations will bring about immediate change – updating factsheets and letter and assessment templates to ensure that key equality and human rights considerations are routinely embedded into processes for example – all the recommendations were designed to bring about tangible change to people using homelessness services in Wales.

The Complaints Standards Authority (CSA) continued its work with public bodies in Wales last year. The model complaints policy has already been adopted by local authorities and health boards in Wales, we have now extended this to an initial tranche of Housing Associations and Natural Resources Wales. The aim being to implement this work across the Welsh public sector.

In addition to this, the CSA published information on complaints handled by local authorities for the [first time](#) – a key achievement for this work. The CSA receives similar data from Health Boards on a quarterly basis in line with Welsh Government reporting responsibilities, and will look to publish this data for the first time later in 2022.

The CSA has now implemented a model complaints policy with nearly 50 public bodies, and delivered 140 training sessions, completely free of charge, during the

last financial year. The feedback has been excellent, and the training has been very popular - so I would encourage Swansea Bay University Health Board to engage as fully as possible.

Complaints made to the Ombudsman

A summary of the complaints of maladministration/service failure received relating to your Health Board is attached.


Finally, can I thank you and your officials for the positive way that health boards have engaged with my Office to enable us to deliver these achievements during what has been a challenging year for everyone. I very much look forward to continuing this work and collaboration to ensure we further improve public services across Wales.

Further to this letter can I ask that your Health Board takes the following actions:

- Present my Annual Letter to the Board and share any feedback from the with my office.
- Continue to engage with our Complaints Standards work, accessing training for your staff, fully implementing the model policy, and providing complaints data.
- Inform me of the outcome of the Board's considerations and proposed actions on the above matters by 30 September.

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,



Michelle Morris
Public Services Ombudsman

Cc. Mark Hackett, Chief Executive, Swansea Bay University Health Board
By Email only: mark.hackett@wales.nhs.uk

Factsheet

Appendix A - Complaints made to PSOW

Health Board	Complaints Received	Received per 1000 residents
Aneurin Bevan University Health Board	142	0.24
Betsi Cadwaladr University Health Board	213	0.30
Cardiff and Vale University Health Board	89	0.18
Cwm Taf Morgannwg University Health Board	113	0.25
Hywel Dda University Health Board	88	0.23
Powys Teaching Health Board	10	0.08
Swansea Bay University Health Board	110	0.28
Total	765	0.24

Appendix B – Complaints made to PSOW by subject

Swansea Bay University Health Board	Complaints Received	% share
Ambulance Services	0	0%
Appointments/admissions/discharge and transfer procedures	3	3%
Clinical treatment in hospital	54	49%
Clinical treatment outside hospital	5	5%
Complaints Handling	20	18%
Confidentiality	0	0%
Continuing care	1	1%
COVID19	4	4%
De-registration	2	2%
Disclosure of personal information / data loss	1	1%
Funding	2	2%
Medical records/standards of record-keeping	0	0%
Medication> Prescription dispensing	0	0%
Mental Health	8	7%
NHS Independent Provider	0	0%
Non-medical services	0	0%
Other	4	4%
Out Of Hours	2	2%
Parking (including enforcement and bailiffs)	0	0%
Patient list issues	4	4%
Poor/No communication or failure to provide information	0	0%
Prisoner Care	0	0%
Referral to Treatment Time	0	0%
Rudeness/inconsiderate behaviour/staff attitude	0	0%
	110	

Appendix C – Complaints closed by PSOW - Outcomes
 (* denotes intervention)

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*	Public Interest Report*	Total
Swansea Bay University Health Board	20	17	36	17	1	2	12	0	105
% share	19%	16%	34%	16%	1%	2%	11%	0%	

Appendix D - Cases with PSOW Intervention

	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%

Information Sheet

Appendix A shows the number of complaints received by PSOW for all Health Boards in 2021/2022. These complaints are contextualised by the number of people each health board reportedly serves.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows outcomes of the complaints which PSOW closed for the Health Board in 2021/2022. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix D shows Intervention Rates for all Health Boards in 2021/2022. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.