

LISTENING & LEARNING SUB COMMITTEE UPDATE REPORT

Date of last meeting: [04 September 2024]

Report by: Chantel Patel, Chair

KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING:

Alert¹

The Listening and Learning Sub-Committee wish to **alert** members to the forthcoming changes to the Putting Things Right (PTR) Regulations, which will be implemented from 1st April 2025. The new process will be more person centred, focussed on improving transparency and trust. There is a greater emphasis on active listening and action as part of an early resolution stage. Currently the early resolution stage requires any concern that cannot be resolved within two working days to be moved into the formal putting things right investigation stage.

The Welsh Government is keen that health bodies maximise every opportunity to resolve concerns as early as possible and is keen to see improvement in this area as soon as possible. Feedback from the Public Services Ombudsman for Wales Annual Report 2023-2024 (enclosed) shows the Health Board has one of the highest intervention rates of all health boards, indicating that improved timeliness for response and resolution is a key priority. This report will be reviewed at the next Listening and Learning Sub-Committee.

The Health Board is already striving to increase the number of early resolution cases and is currently trialling a new triage and engagement process within the concerns hub/Patient Advice and Learning Service (PALS) service, which is resulting in a higher percentage of cases being resolved at this stage. This is a more responsive and action focussed arrangement which will lead to improved satisfaction, timeliness and learning opportunities.

As part of the preparedness for implementation, the Listening and Learning Sub-Committee agreed that the current timeframe of 2 working days for an early resolution be increased to 10 working days, in advance of the formal implementation date of the new Regulations from 1st October 2024. The Quality, Safety and Experience Committee is asked to endorse this decision which will effect a complaint handling policy change for the remainder of the financial year.

Assure

The Listening and Learning Sub-Committee wish to assure the Quality, Safety and Experience on the following matters:

Maternity Services

A selection of patient stories, feedback, concerns, claims and redress cases relating to maternity care were reviewed.

¹ There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

A number of presentations were received from the Interim Head of Midwifery and Patient Experience Midwife in response to the themes and trends arising from the cases. It was evident that there was multi-disciplinary review of the feedback and learning from cases, this resulted in targeted actions and regular effectiveness meetings. A number of significant improvements had been made as a result, including:

- Accessibility of information in Welsh, English and other languages.
- Educational videos to inspire.
- Birthing Environment – Galaxy lighting in the Obstetrics’ room.
- Biomechanics Video – Visually demonstrate equipment for greater understanding and managing expectations.
- Video created to talk patients through procedures;
- Planned family approach to Caesarean births.
- The Matterport project simulation was created. (Please see further detail below).

Public Services Ombudsman for Wales – three final reports were received by the Sub-Committee. Assurance was received that action plans were in place and there were no risks to the compliance deadlines for submitting evidence of implementation of actions to the Ombudsman. Two public interest reports issued to other health boards were received and would be distributed to the appropriate services for wider learning.

Sharing of learning

The ‘Matterport’ project simulation was created by the maternity service, it is a 360 walk through of the maternity unit. This platform is easily accessible. Currently only showing Glangwili Hospital facilities with plans to roll this out across other units. This is available 24/7 for viewing by families in the comfort of their own home, they will be able to view amenities to inform them and be able to prepare for any upcoming appointments and also can be used by new members of staff to aid orientation and emergency training.

This application will reduce the need for on-site visits and reduce foot fall within the unit, within the site as a whole, and improve infection control.

Added extras currently being considered includes the ability to click on a particular object and it will give you a description of its use not just written but a video to help those with limited reading capabilities. The Sub-Committee agreed that the Matterport had significant benefits and is a valuable resource.

The Sub-Committee noted that the resource would benefit from a wider application to improve accessibility across all health board areas and would help to improve ‘did not attend rates’; alleviate patient/carer anxieties; manage expectations and help to resolve many of the issues highlighted in the Llais Wayfaring Report on how to access and attend appointments.

Recommendation

The Committee is asked to note the report and endorse the proposal to amend the current ‘early resolution’ timescale of the PTR policy to 10 working days.



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Ask for:

Communications



01656 641150



Caseinfo@ombudsman.wales

Date: 9 September 2024

Dr Neil Wooding
Hywel Dda University Health Board

By email only

Neil.Wooding@wales.nhs.uk
Kelly.E.Sursona@wales.nhs.uk

Annual Letter 2023/24

Dear Neil

Role of PSOW

As you know, the role of the Public Services Ombudsman for Wales is to consider complaints about public services, to investigate alleged breaches of the councillor Code of Conduct, to set standards for complaints handling by public bodies and to drive improvement in complaints handling and learning from complaints. I also undertake investigations into public services on my own initiative.

Purpose of letter

This letter is intended to provide an update on the work of my office, to share key issues for health boards in Wales and to highlight any particular issues for your organisation, together with actions I would like your organisation to take.

Overview of 2023/24

This letter, as always, coincides with my Annual Report – “A New Chapter Unfolds” – and comes at a time when public services continue to be in the spotlight, and under considerable pressures. My office has seen another increase in the number of people asking for our help – a 17% increase in overall contacts compared to the previous year, with nearly 10,000 enquiries and complaints received. Our caseload has increased substantially - by 37% - since 2019.

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0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
Rydym yn hapus i dderbyn ac
ymateb i ohebiaeth yn y Gymraeg.

ombudsman.wales
ask@ombudsman.wales
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
We are happy to accept and respond
to correspondence in Welsh.

During 2023/24 we considered and closed more enquiries and complaints than we ever have done before, and we reduced the average cost for each case and investigation. We started the year with a focus on reducing our aging cases, those over 12 months old, by 50% by the end of the year. These cases are often the most complex and distressing for the people making the complaint. I am extremely pleased to say we exceeded this target, reducing our aged investigations by over 70%. We are now well on track to meeting our objective to complete investigation of complaints within 12 months.

Public Service Complaints and compliance with recommendations

We received 939 complaints about health boards last year – roughly the same number as the previous year. During this period, we intervened in (upheld, settled or resolved at an early stage) 31% of health board complaints - a similar proportion to previous years.

Last year, we received 138 complaints about Hywel Dda University Health Board, we closed 154 (some complaints were carried over from the previous year) and intervened in 36% of cases. Further information on the complaints we dealt with last year can be found in the appendices.

In total, we made 160 recommendations to your health board during the year. To ensure that our investigations and reports drive improvement, we follow up compliance with the recommendations agreed with your organisation. In 2023/24, 151 recommendations were due and 81% were complied with in the timescale agreed. The remainder were complied with, but outside the timescales agreed, or remained outstanding as at 9 April 2024.

Recommendations and timescales for complying with recommendations are always agreed with the public body concerned before being finalised, and we therefore expect organisations to comply within the timescales agreed.

Further to the report my office issued in June 2023, [Groundhog Day 2: An opportunity for cultural change in complaint handling?](#) I wish to thank the Health Board for its consideration of the report and recommendations. I trust that it has ensured that lessons learned from the PSOW's findings and recommendations on cases we considered last year are included in your Health Board's Annual Report on the Duty of Candour and Quality.

Supporting improvement of public services

We continued our work on supporting improvement in public services last year and worked on our second wider Own Initiative investigation. The investigation considers carers' needs assessments undertaken by local authorities in Wales. My report on this work will be finalised report and published in the near future.

We have continued our work on complaints handling standards for public bodies in Wales and now have 56 public bodies following our model complaints handling policy. These public bodies account for around 85% of the complaints we receive.

We continued our work to publish complaints statistics into a third year with data, gathered from public bodies, now published twice a year. This data allows us to see information with greater context – for example, last year 6% of complaints made to Hywel Dda University Health Board’s complaints went on to be referred to PSOW. I would encourage all health boards to use this data to better understand their performance on complaints and ensure that all complaints are appropriately logged.

Colleagues from my Improvement Team continue to meet regularly with Hywel Dda University Health Board to discuss compliance with our recommendations and our complaints standards work. We have seen real benefit come from these conversations, as well as improved working relationships, and we would like to pass on our thanks to Olivia Barker and their team for their work with our officers.

Action we would like your organisation to take

Further to this letter can I ask that Hywel Dda University Health Board takes the following actions:

- Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.
- Consider the data in this letter, alongside your own data, to understand more about your performance on complaints, including any patterns or trends and your organisation’s compliance with recommendations made by my office.
- Provide my office with a copy of the Health Board’s Annual Report for 2023/24 on the Duty of Candour and Quality
- Inform me of the outcome of the Board’s considerations and proposed actions on the above matters at your earliest opportunity.

Finally, I would like to thank you, and your teams, for your work with my officers in the last year. Their work is important in ensuring that patients and families receive timely and thorough responses to complaints, and in improving outcomes for all service users – not just those who complain.

Yours sincerely,

Michelle Morris

Michelle Morris
Public Services Ombudsman

Cc. Phil Kloer, Chief Executive, Hywel Dda University Health Board



Factsheet

Appendix A - Complaints Received

Health Board	Complaints Received	Received per 1,000 residents
Aneurin Bevan University Health Board	175	0.30
Betsi Cadwaladr University Health Board	214	0.31
Cardiff and Vale University Health Board	150	0.30
Cwm Taf Morgannwg University Health Board	109	0.25
Hywel Dda University Health Board	138	0.36
Powys Teaching Health Board	21	0.16
Swansea Bay University Health Board	132	0.35
Total	939	0.30



Appendix B - Received by Subject

Hywel Dda University Health Board	Complaints Received	% share
Admissions/discharge and transfer procedures	0	0%
Adult Mental Health	9	5%
Ambulance Services	0	0%
Appointment procedures (including outpatients)	5	3%
Child and Adolescent Mental Health	1	1%
Clinical treatment in hospital	56	41%
Clinical treatment outside hospital*	8	6%
Complaints Handling	32	23%
Covid-19	3	2%
Continuing care	3	2%
De-Registration	0	0%
Disclosure of personal information / data loss	0	0%
Funding	2	1%
Independent Health Care providers	0	0%
Medical records/standards of record-keeping	2	1%
Medication > Prescription dispensing	0	0%
Non-medical services	2	1%
Nosocomial*	0	0%
Other*	6	4%
Out of Hours GP care	0	0%
Parking (including enforcement and bailiffs)	0	0%
Patient list issues	4	3%
Poor/No communication or failure to provide information	0	0%
Prisoner Care	0	0%
Recruitment and appointment procedures	0	0%
Referral to Treatment Times	2	1%
Regulation and Inspection (including private sector provision)	0	0%
Rudeness/inconsiderate behaviour/staff attitude	0	0%
Services for people with a disability inc DFGs	1	1%
Service for vulnerable Adults (eg with learning difficulties or mental health issues)	0	0%
Total	138	



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Appendix C - Complaint Outcomes (* denotes intervention)

Hywel Dda University Health Board		% Share
Out of Jurisdiction	28	18%
Premature	25	16%
Other cases closed after initial consideration	42	27%
Early Resolution/ voluntary settlement*	37	24%
Discontinued	0	0%
Other Reports - Not Upheld	4	3%
Other Reports Upheld*	18	12%
Public Interest Reports*	0	0%
Special Interest Reports*	0	0%
Total	154	



Appendix D - Cases with PSOW Intervention

	No. of Interventions	No. of Closures	% of Interventions
Aneurin Bevan University Health Board	73	195	37%
Betsi Cadwaladr University Health Board	81	256	32%
Cardiff and Vale University Health Board	34	158	22%
Cwm Taf Morgannwg University Health Board	39	129	30%
Hywel Dda University Health Board	55	154	36%
Powys Teaching Health Board	3	21	14%
Swansea Bay University Health Board	41	141	29%
Total	326	1054	31%



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Appendix E – Compliance performance comparison

Health Board	Number of recommendations made in 2023-24	Number of Recommendations falling due in 2023-24	% of recommendations, complied with on time
Aneurin Bevan University Health Board	209	208	75%
Cardiff and Vale University Health Board	104	95	81%
Cwm Taf Morgannwg University Health Board	123	121	60%
Swansea Bay University Health Board	119	127	62%
Hywel Dda University Health Board	160	151	81%
Betsi Cadwaladr University Health Board	253	246	58%
Powys Teaching Health Board	10	12	67%



Information Sheet

Appendix A shows the number of complaints received by PSOW for all Health Boards in 2023/24. 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 2023/24. 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 2023/24. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

Appendix E shows compliance performance for all Health Boards.