Cafodd yr ymateb hwn ei gyflwyno i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Flaenoriaethau'r Chweched Senedd

This response was submitted to the Health and Social Care Committee consultation on Sixth Senedd Priorities

HSC PSS 127

Ymateb gan: | Response from: Ombwdsmon Gwasanaethau Cyhoeddus Cymru | Public Services Ombudsman for Wales

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Mae'r ymateb yma hefyd ar gael yn Gymraeg.

This response is also available in Welsh.

Ombwdsmon Ombudsman
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

Response by the Public Services Ombudsman for Wales

to the Health and Social Care Committee's consultation on their priorities for the Sixth Senedd.

I am pleased to have the opportunity to respond to the Health and Social Care Committee's consultation on their priorities for the sixth Senedd.

Our role

As Public Services Ombudsman for Wales (PSOW), I investigate complaints made by members of the public who believe they have suffered hardship or injustice through maladministration or service failure on the part of a body in my jurisdiction, which essentially includes all organisations that deliver public services devolved to Wales. These include:

- local government (both county and community councils)
- the National Health Service (including GPs and dentists)
- registered social landlords (housing associations)
- the Welsh Government, together with its sponsored bodies.

I can consider complaints about privately arranged or funded social care and palliative care services and, in certain specific circumstances, aspects of privately funded healthcare.

I also investigate complaints that elected members of local authorities have breached their Codes of Conduct, which set out the recognised principles of behaviour that members should follow in public life.

The 'own initiative' powers I have been granted under the Public Services Ombudsman (Wales) Act 2019 (PSOW Act 2019) allow me to investigate where evidence suggests there may be systemic failings, even if service users themselves are not raising complaints. The Act also establishes the Complaints Standards Authority (CSA) to drive improvement in public services by supporting effective complaint handling through model procedures, training and collecting and publishing complaints data.

Themes from my Casework

Health complaints make up the bulk of the complaints I handle. 39% of all the complaints received in 2020/21 were about health services. The complaints I receive play a critical role in upholding justice for people where public services have failed for them. Complaints are an important indicator of systemic problems and provide opportunities for learning that can help improve support services across the wider public service. My casework data allows me to identify some general themes of the problems service users face in the potential priorities, which the Committee may find useful in determining the focus for their work over the next Senedd. I have shared cases from my Casebook that exemplify some of these themes.

Mental Health

The complaints I have upheld in recent years suggest that the treatment of patients with mental health conditions has for the most part been fair. However, they do highlight potential issues relating to medication management, and assessments, poor record-keeping, as well as poor communication with patients, their families and service and care providers. The impact of these failings has at times been exacerbated by poor complaint handling.

Powys Teaching Health Board & Aneurin Bevan University Health Board - Clinical treatment in hospital Case Number: 201902970 & 201803603 – Report issued in November 2019

Mrs M complained that failings in the care and treatment that her daughter, Ms D, received from Aneurin Bevan University Health Board's Mental Health Services in late 2015 (services commissioned by Powys Teaching Health Board), contributed to her tragic suicide in January 2016. Mrs M complained about: a) Failings in the Consultant Psychiatrist's management of Ms D's medication in the weeks prior to her death. b) The failure of a Mental Health Social Worker to recognise and appropriately respond to Ms D's psychotic symptoms during and following an emergency consultation in November 2015. c) A series of failures of communication between Mental Health Services and the family.

I identified significant failings in Ms D's care and, consequently, upheld these complaints. However, I found no evidence to suggest that these failings caused or contributed to Ms D's tragic suicide.

Swansea Bay University Health Board - Clinical treatment in hospital Case Number: 201901025 - Report issued in August 2020

Mrs X complained that her adult son, Mr Y, was not properly assessed in relation to discharging him from detention under section 2 of the Mental Health Act 1983; that Mr Y was transferred inappropriately from a Psychiatric Hospital to a General Hospital; that communication was poor and that Mr Y did not receive appropriate care after being discharged from detention. Mrs X also complained that her complaint was not handled properly by the Health Board. The investigation found that Mr Y had been assessed by a Consultant Psychiatrist before he was discharged from detention under section 2, and was assessed by 2, General Physicians before he was discharged from hospital. It also determined that the

transfer of Mr Y from the Psychiatric Hospital to the General Hospital was appropriate and did not uphold the first 2 aspects of Mrs X's complaint. The investigation learned that there was confusion between staff about why Mr Y had been transferred to the General Hospital, and whether he was to be transferred back to the Psychiatric Hospital prior to his discharge, and about whether Mr Y had been discharged from detention. This caused the family and Mr Y an injustice because they were left without answers at a very stressful time. The complaint that Mr Y did not receive appropriate care following his discharge was also upheld because Mr Y did not receive follow up care in line with good practice, even though his family continued to express concerns about his health. Finally, Mrs Y's complaint that her concerns were not addressed appropriately by the Health Board was upheld due to delays in communicating with her and conflicting information in the responses.

Cwm Taf Morgannwg University Health Board - Clinical treatment outside hospital Case Number: 201903590 - Report issued in September 2020

Mrs M complained that failings in the care and treatment that her late son, Mr B, received from mental health services provided by the Health Board, contributed to his tragic suicide in February 2018. Mrs M complained that: a) Assessments and care-management interventions conducted by clinicians during 2016 and 2017 failed to adequately identify and treat Mr B's deteriorating mental health. b) Clinicians failed to appropriately exercise their powers to detain Mr B under the provisions of the Mental Health Act 1983 ("the MHA"). c) Clinicians failed to follow up or further engage with Mr B after his discharge from the Royal Glamorgan Hospital ("the Hospital"). d) following Mr B's suicide on 27 February 2018, the family went to view his body at the Hospital's Emergency Department ("ED") and were shocked to discover that no attempt had been made to conceal the ligature marks around Mr B's neck or the bruising sustained in attempts made to resuscitate him.

I did not uphold complaints 1 and 2. I found that the care that Mr B received from clinicians during 2016 and 2017 was of a good standard and that there were no grounds to detain Mr B under the provisions of the MHA. I upheld complaint 3 and determined that Mr B's discharge was unsatisfactory. However, I could not conclude that an inadequate discharge plan directly caused or contributed to Mr B's subsequent deterioration (and decision to end his life some 3 months later). I upheld complaint 4 and concluded that the failure to protect Mr B's dignity in death and to take steps to ensure that the family's distress was minimised were serious shortcomings that were a source of significant injustice to the family. Finally, I concluded that, despite the identified shortcomings, I saw no compelling, causal evidence that could definitively link Mr B's decision to end his life to the actions or omissions of clinicians.

Unpaid Carers

Poor communication between carers with service providers is a common theme in the complaints, as is failure to provide support for care funding. Often these failures can be a result of poor planning and communication across different sectors of the public service. Maladministration in service provision for service users has a direct subsequential impact for their carers, as they try to meet the caring needs that services have failed to supply.

Conwy County Borough Council and Betsi Cadwaladr University Health Board - Services for vulnerable adults Case Number: 201900898 & 201806745– Report issued in January 2020

Ms A complained the Council and the Health Board failed to consider her mother's application for NHS Funded Continuing Health Care ("CHC") in a timely manner and that the decision was pre-judged, procedurally incorrect and therefore failed to consider her mother's needs at the time. She also complained about the Council's handling of her complaint. In relation to the Health Board, Ms A said that it failed to carry out an assessment of her mother's application for CHC and had accepted the Council's decision and therefore failed to independently consider her mother's needs.

My investigation found that a lack of clarity around the CHC process, including deviations from the CHC process by both the Council and the Health Board, contributed to poor communication and misunderstanding about the process which caused Ms A distress. I recommended that both the Council and the Health Board apologise to Ms A. The Council and the Health Board were asked to work collaboratively to ensure that a CHC process is developed, along with clear guidance, about the CHC process so that individuals, relatives and carers are aware of what steps they could take if they remained unhappy with the CHC outcome, as well as to put a mechanism in place for ensuring that planned reviews are undertaken in a timely manner.

Newport City Council – Services for vulnerable adults Case Number 201607041 - Report issued in April 2017

Mrs L complained that Newport City Council ("the Council") reduced her sister's respite care package but made its decision without seeing her and before carrying out the appropriate assessments. On appeal, the care package was increased slightly, but not to the previous level and Mrs L explained this had a detrimental effect on her sister and her carers. The Council refused to escalate Mrs L's concerns through the statutory Social Services Complaints Procedure on the grounds that this process cannot be used to lodge an appeal against a decision. I found that Mrs L's concerns around the process followed in making the decision, particularly in relation to the timeline of the assessments that were made, were matters that should be considered via an independent review and were matters appropriate to be considered under the Social Services Complaints process.

Long-term chronic conditions, including musculoskeletal conditions (MSK)

The complaints I receive suggest that taking both a whole-system and person-centred approaches is an important step in the development and improvement of health and social care services for people who suffer with long-term chronic conditions such as MSK and arthritic conditions. However, there are some areas where this holistic approach could be strengthened.

With one or two exceptions, the majority of complaints about MSK and arthritic care that we uphold typically relate to poor practices in record-keeping, poor communication between primary, secondary care and other care providers and poor-quality housing that exacerbates existing conditions. Many also demonstrate inadequate complaints handling by care providers. These types of concerns place additional unnecessary stress on MSK sufferers. I wish to draw attention to 2 cases, to provide insight into the stories of real people behind the complaint statistics.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital Case Number: 201806766 - Report issued in February 2020

Mrs C's daughter was concerned about the care and management of her late mother's Barrett's oesophagus diagnosis at the Princess of Wales Hospital and that the condition might have contributed to her mother's severe reaction when she had osteoporosis treatment. She was also concerned about a breakdown of communication with the family and her mother, during her mother's last inpatient admission. She also complained about the adequacy of the Health Board's complaint response. Whilst I found that the care was appropriate, I did identify communication shortcomings which were not helped by inadequate record-keeping. Additionally, the Health Board's complaint handling was insufficiently robust. This was an injustice to Mrs C's daughter and her family. I recommended that the Health Board should apologise to for the communication and complaint handling failings and, as requested by Mrs C's daughter, pay to her named charity the £250 complaints handling redress payment it had offered. The Health Board was also asked to consider providing its clinicians with communication training.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number: 201807683 – Report issued in April 2020

Mrs A complained about her late husband's management and care by Hywel Dda University Health Board's Glangwili General Hospital. Mr A, who suffered from rheumatoid arthritis, had started taking the immunosuppressant drug methotrexate, for the condition. Mr A was admitted to the Hospital in November and died from methotrexate-induced pneumonitis (a life-threatening lung disease which is a rare complication of methotrexate) in January 2018.

I found that Mr A's respiratory management and care during his inpatient admission was appropriate and reasonable so did not uphold this aspect of Mrs A's complaint. Administratively, I found failings around the Health Board's complaint handling process. These related to delay and the robustness of the investigation which extended to learning lessons. As these failings caused Mrs A an injustice, I upheld this part of her complaint and recommended that, the Health Board should improve

its consenting process when its rheumatology department prescribed methotrexate. Additionally, the Clinical Director for Primary Care was asked to write to GP Practices in the Health Board's area setting out the risks, although rare, of methotrexate-induced pneumonitis, using Mr A's case as an example.

Closing remarks

I trust that you will find my comments useful. Should you wish to discuss any of my points further, please do not hesitate to contact [redacted] my acting Head of Policy [redacted]

Nick Bennett

Public Services Ombudsman for Wales

January 2021