Special Report issued under s28 of the Public Services Ombudsman (Wales) Act 2019 following a complaint made by Mrs A against Powys Teaching Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202001997

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Introduction

This report is issued under section 28 of the Public Services Ombudsman (Wales) Act 2019 ("the Act").

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mrs A and to members of staff of Powys Teaching Health Board by their post designation.

Summary

Mrs A had complained to Powys Teaching Health Board ("the Health Board") and a second local health board in July 2019 concerning the care and treatment that had been provided to her mother. The Health Board was the lead relevant body for the purposes of the investigation in accordance with the statutory regime for dealing with healthcare related complaints (commonly known as Putting Things Right – "PTR"). Mrs A complained to the Ombudsman in January 2020. She outlined why she was dissatisfied with the care and treatment provided to her mother and she asked the Ombudsman to investigate the Health Board's handling of her complaint as it had not provided her with a complaint response, despite her chasing up the lack of response. In accordance with his powers, the Ombudsman resolved the complaint (as an alternative to investigation) on the basis of the Health Board's agreement to the following 2 actions; it would provide Mrs A with a written apology and a complaint response by 14 February 2020.

Being dissatisfied that the Health Board had not complied with either of the 2 recommendations within the timescales agreed, the Ombudsman invoked his powers under section 28 of the Act to issue a Special Report. This was critical of the Health Board's handling of Mrs A's complaint and its failure to implement the recommendations that it had expressly agreed to.

The Ombudsman made 2 further recommendations to the Health Board:

(a) To issue a written apology to Mrs A's for the way in which it has handled her complaint.

(b) Within 2 months of the final report, that the Health Board's CEO personally responds to the Ombudsman, having undertaken a review of its complaints handling team and its ability and capacity to deal with complaints under the PTR regime in an effective and timely way. This review should consider not only capacity but whether additional training on the PTR requirements should be undertaken.

My Jurisdiction

1. Under the provisions of the Act, pursuant to section 6, I am able to take any action I consider appropriate to resolve a complaint as an alternative to investigating it. This can include agreeing with a relevant body that it will take certain actions within a stipulated time. Where I am not satisfied that the relevant body has carried out the actions it explicitly agreed to undertake within the time stipulated, I may issue a special report.

The Background

2. Mrs A complained to me about Powys Teaching Health Board ("the Health Board") on 23 January 2020. In her complaint to me, Mrs A explained that on 29 July **2019** she had complained to both the Health Board and another local health board ("the Second Health Board") about the care and treatment her late mother had been afforded. That complaint had been submitted to be dealt with in accordance with the NHS Redress Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 (commonly referred to as "Putting Things Right" – "PTR").

3. Under PTR, when a person makes a complaint that involves the actions of more than one responsible body, the first and second body must co-operate for the purposes of co-ordinating the handling and consideration of the complaint and ensuing that the complainant receives co-ordinated responses. There is a duty on the bodies to seek to agree which will take the lead and communicate with the complainant.[1]

4. Under PTR, unless it is considered that a "qualifying liability" may exist as a result of possible harm to the patient (when different rules apply), all reasonable attempts should be made by the relevant body to provide a complaint response within 30 working days of receiving it. If unable to do so, the relevant body should inform the complainant of the reasons why it cannot do so and send the complaint response "as soon as reasonably practicable and within six months". PTR does go on to say that in

[1] PTR Regulations 17 (3) and (4)

"exceptional circumstances" where a relevant body cannot adhere to the 6-month period, the complainant must be informed of the reasons for the delay and when a response might be expected. [2]

5. Following receipt of Mrs A's complaint, a Casework Officer from my Complaints Advice Team ("the CO") contacted the Health Board to discuss the complaint. A representative of the Complaints Team ("the Officer") confirmed via email, on 5 February **2020**, that the Health Board had received Mrs A's complaint and an investigation into her concerns had already commenced. The Officer said that as most of the issues needed to be addressed by the Health Board, it had taken the lead in complaint handling, with additional information being sought from the Second Health Board. The Officer said that a delay had occurred due to the number of people that the Health Board needed to contact in order to inform its complaint response. The Officer said that the deadline for receipt of the final comments from clinicians was 7 February. Once received, the Health Board would be in a position to provide Mrs A with a complaint response. It was envisaged that Mrs A would receive the complaint response no later than 14 February; this would allow the Health Board time to go through its quality checking process and for the complaint response to be signed off by the Chief Executive Officer ("CEO"). The Officer offered Mrs A an apology for the delay.

6. In light of the information provided by the Health Board, by way of early settlement of Mrs A's complaint (in accordance with my powers set out in paragraph 1), the CO considered that the actions proposed by the Health Board were sufficient to resolve Mrs A's complaint. The early settlement letters were sent on 10 February and outlined the Health Board's intention to; apologise to Mrs A for the delay in responding to her complaint and to issue a complaint response by 14 February. The Officer acknowledged safe receipt on 13 February.

Implementing the Recommendations

7. On 2 March Mrs A contacted the CO to say that she had not received any correspondence from the Health Board. Mrs A sought advice on how best to proceed.

[2] PTR Regulations 24 (3) (4) and (5).

8. On 3 March the CO contacted the Officer and the Assistant Director, Quality and Safety ("the Assistant Director") enquiring if the complaint response had been sent to Mrs A. Receipt of the email was acknowledged by the Assistant Director, who said that she would speak to the Complaints Team the following day. The CO responded to inform that the Ombudsman would have to consider issuing a Special Report due to the Health Board's non-compliance.

9. On 5 March the Assistant Director emailed the CO and said that additional information had been requested and had subsequently been received (that day). The Assistant Director envisaged that the complaint response would be completed and "signed off" by 13 March and Mrs A would receive it no later than 16 March. The Assistant Director asked that an apology be provided to Mrs A for the delay. The CO updated Mrs A.

10. On 7 April the Officer emailed the CO and apologised for the continuing delay in providing Mrs A with a complaint response. She said that the Health Board was still waiting on a key clinician to address the concern raised. The Officer said that the complaint response would be provided urgently but no timescales could be given due to the position that all health boards were currently in (due to the impact of the COVID-19 pandemic). Again, the Officer asked that an apology be provided to Mrs A for the continued delay.

11. The following day, the CO emailed the Officer and said that the matter would be placed on hold until July. In the meantime, if a complaint response was sent to Mrs A, the CO asked that the Ombudsman be informed. The CO updated Mrs A.

12. On 16 June the Officer wrote to the CO to inform her that the Health Board had all the information required in order to finalise the complaint response. The complaint response was going through the quality checking process and, as soon as the CEO had signed it, an update would be provided. Coincidentally, Mrs A contacted the CO for an update on the same day. She was informed of the Health Board's position.

13. The CO contacted the Officer on 6 July for an update. On 7 July the Officer informed her that the complaint response was being approved by the Second Health Board in respect of its findings and the Health Board had chased it for a response.

14. The CO emailed the Officer again on 27 July requesting an update.

15. Mrs A informed the CO on 28 July that she intended to escalate matters if she did not receive the complaint response within 10 days. The CO informed Mrs A that she was continuing to liaise with the Health Board.

16. On 30 July the Officer responded to the CO's email of 27 July. She said that the complaint response was still with the Second Health Board as its comments were being approved by one of its Consultants.

17. On 4 August an Assistant Investigation Manager from my Investigation Team discussed the complaint with the Concerns Manager at the Second Health Board. The Concerns Manager said that the comments on the complaint response had been sent to the Health Board on 15 June. The Concerns Manager said that as there appeared to be a breach of duty of care in relation to an aspect of the complaint concerning the actions of the Second Health Board, the Health Board had requested that it deal with that matter separately and progress the issue through its own redress process. The Concerns Manager said that it was in the process of doing this. As far as the Concerns Manager was aware, there was nothing for the Second Health Board to "sign off" as it was taking matters forward separately. The Concerns Manager said that the Second Health Board had not updated Mrs A as it had not been sure whether the Health Board would be undertaking that task.

18. The CO contacted the Officer and the Assistant Director on 5 August and notified them of the discussions held with the Second Health Board. She expressed her dissatisfaction that neither Mrs A nor the Ombudsman had been updated. The CO asked that a meaningful update be provided to Mrs A and asked for clarification as to whether what the Second Health Board said was factually correct and, if so, why the Health Board's internal systems were noting that information was still awaited. The CO's

email was first met with an automated response indicating that the Officer was on leave. Later that day the Assistant Director replied to say that she would need to ask staff for an update before responding.

19. Mrs A was updated with the above information by the CO on 7 August.

20. Mrs A contacted the CO on 17 August to say that she still hadn't received a complaint response from the Health Board. Mrs A intended to write to both her late mother's MP and the Health Board's CEO asking for an update on the status of her complaint (which she subsequently did).

21. On 18 August the CO wrote to both the Officer and the Assistant Director asking for a further update. A response was received from the Officer who said that there had been some confusion. Whilst the Health Board was the lead for the purposes of the complaint response, it said that it could not make any admission in respect of a breach of duty of care on behalf of the Second Health Board. The Officer said that when the Second Health Board advised that it would address the queries posed by the Health Board, it had been assumed that it would present the complaint to its own Redress Panel and update Mrs A itself. The Officer apologised that this had not happened. She said she planned to liaise with the Second Health Board as a matter of urgency.

22. On 28 August Mrs A received an email from the Officer expressing her sincere apologies that she had not received any communication from the Health Board about her complaint. She said that there appeared to be a misunderstanding as to who would remain in contact with Mrs A to keep her appraised of the progress of the complaint response. Mrs A was informed that the complaint response was going through the quality checking process and the Officer would endeavour to ensure that the complaint response was sent as a matter of priority.

23. On 14 September an Investigation Officer from my Investigation Team contacted the Officer to seek a further update. On 30 September the Officer responded and said that the complaint response had been reviewed and clarification had needed to be sought from a clinician on a few outstanding points. The comments were still awaited, and an anticipated timescale for receipt could not be provided. The Officer updated Mrs A directly that day.

24. On 2 October Mrs A was informed by the Officer that the outstanding comments had been received and consequently the complaint response could be finalised. As the CEO's office was closed at the time of correspondence, the Officer said that a further update would be provided to Mrs A on 5 October. As agreed, Mrs A was informed on 5 October that the complaint response would be sent via email by close of business on 12 October. Mrs A received a complaint response on 12 October.

The Health Board's comments on a draft of this report

25. The Health Board said that it took the nature of this report extremely seriously and apologised unreservedly for the failings identified. The Health Board confirmed that it accepted my recommendations and would ensure their implementation.

26. As a consequence of this report, the Health Board informed me that a fact-finding assessment would be undertaken in relation to events set out above; the key members of staff (referred to within this report) would have the opportunity to contribute to the process.

27. The Health Board said that it is a commissioner of services from a range of providers across Wales and England and this complex situation often impacted on managing complaints across multiple organisations. It was keen to access support (including from my office) in relation to the preparation of complaint responses as soon as possible.

Analysis and Conclusions

28. The Health Board's proposed action was agreed by the CO, on my behalf, as an early resolution and this was formalised in a letter from the CO on 5 February (see paragraph 6), however, the Health Board failed to comply within the timescales stipulated.

29. It is evident that the Health Board was in no position to fulfil the agreement that it entered into with my office in February. The correspondence received from the Health Board prior to the early settlement being agreed implied that the complaint response was almost complete (or at least in the latter stages of drafting). It was in fact the Health Board that

signalled that it could provide a resolution to Mrs A's complaint within a short timeframe and the original short timeframe was not one proposed or indeed imposed on it by my office. The timeframe regularly used by my office in entering settlements such as here, is within one month. However, it is open to a public body to propose and agree to a lesser time, as happened here.

30. I have monitored the impact that the COVID-19 pandemic has had on key public services and have been sensitive to the pressures upon them, particularly health boards.[3] However, the failure of the Health Board to initially comply with the agreement pre-dates the full effect of the pandemic as its response was due in mid-February. At the start of March, the Health Board led me to believe that all the necessary information had been obtained in order for the complaint response to be drafted and that it would be completed and sent to Mrs A within 7 working days, however, a response did not materialise. When it became apparent in April (when pressures on public services were rising), that the complaint response was not near completion (despite the assurances given in March), my CO offered the Health Board a reprieve until July. This was in line with the position I had taken as explained above. It was the Health Board that re-established contact in June to inform my CO that the complaint response was complete and going through quality assurance.

31. More recently, the Health Board indicated that the actions of the Second Health Board were impacting on its ability to comply with its agreement. I suspect that there has been some confusion around how to conclude the joint investigation as PTR is not prescriptive on the issue and these types of investigations are not commonplace. Nevertheless, what PTR is clear on, is that the Health Board, having agreed to be the lead body, is responsible for keeping the complainant informed. It has distinctly failed in that responsibility from the events set out above. Until the very latter stages of the investigation, it has been left to my CO to keep Mrs A updated. That was the Health Board's responsibility as my office's formal involvement at that stage was complete when the settlement was agreed in February. It is evident that there has been poor communication between the two Health Boards with my office having to act as the "the middleman" in August, in an attempt to ascertain the reasons for the stalemate that

[3] https://www.ombudsman.wales/blog/2020/04/28/covid-19-update-3/

occurred. Mrs A was once again informed on 28 August that all the information had been received from the Second Health Board, the issues had been resolved and the complaint response was going through quality assurance. Nevertheless, once again, it was identified that further information was needed, and it took a further 6 weeks for the complaint response to make its way to Mrs A.

32. At the point that Mrs A received her complaint response, compliance was 7 months (very nearly 8 months) overdue. Mrs A waited 14 months, in total, for a response to her concerns. I accept that a complaint response within 30 days could pose a challenge for an NHS body properly investigating a complaint, especially when the investigation involves two local health boards, however, a period of 14 months (even taking into account the pressures on health bodies as a result of Covid-19) is a significant and unacceptable delay. The delay also potentially compromises my office if Mrs A is unhappy with the long-awaited complaint response she has now received; it is more difficult for my staff to meaningfully investigate historical matters. It is why the Act sets a starting point of generally expecting complaints to reach me within 12 months of events.

33. I consider that the information received from the Health Board has been misleading, the updates provided by the Health Board have done nothing but raise Mrs A's expectations that a resolution to her complaint was forthcoming. This is not in keeping with the spirit of PTR; Mrs A has not had her concern dealt with efficiently and openly.

34. It is disappointing that Mrs A waited 13 months to have any meaningful update from the Health Board regarding the status of her complaint. The Health Board said that there was some confusion about which body should have been providing her with updates. The duty imposed via PTR on communication is clear, as I set out above. There needs to be an agreement as to which body will take the lead and communicate with the complainant; in this instance it is the Health Board. In addition to the obligations set out within PTR, the Health Board is the subject of Mrs A's complaint, it expressly agreed to provide her with both a complaint response and apology in its communications with my office, therefore I would have expected it to have directly updated Mrs A periodically after the date for compliance had passed and offer an apology for the continued delay.

I am pleased to note that towards the end of August, the Health Board endeavoured to keep Mrs A updated on the status of her complaint. However, overall, I consider that the Health Board's liaison with Mrs A showed her a lack of respect and courtesy.

35. The events giving rise to me issuing this report give me significant cause for concern about the Health Board's management of its complaint handling function and also its candour. The Health Board expressly agreed to undertake 2 actions. As a consequence of its promise, I did not undertake an investigation into its complaint handling. A resolution under section 6(1) of the Act is just as important as formal recommendations made following a full investigation. It has since provided this office with a number of updates as to the status of the complaint response, but unfortunately the Officer's responses have at best been overly optimistic and at worst disingenuous and misleading. I consider it unacceptable for a major public body to fail to take prompt and effective actions to ensure that agreed recommendations are implemented, and to fail to live up to what are, in effect, binding promises to me as Ombudsman. This is only the second time that I have had reason to invoke my powers to issue a special report against an NHS body for failing to implement agreed actions. It is the first such report under section 28 of the Public Services Ombudsman (Wales) Act 2019 against any public body.

36. I am aware from my office's communications with Mrs A throughout these events that Mrs A was losing confidence in the Health Board's ability to respond to her complaint openly and appropriately. This is not surprising in the circumstances.

37. Also, in view of the confusion in relation to shared responsibilities for the joint investigation of complaints and concerns under the PTR scheme, I am sharing this Report with the Welsh Government.

Further Recommendations

38. I expect and **recommend** that the Health Board:

a) Issue a written apology to Mrs A's for the way in which it has handled her complaint.

b) I further require that the Health Board's CEO personally responds to me, **within 2 months** of this report, having undertaken a review of its complaints handling team and its ability and capacity to deal with complaints under the PTR regime in an effective and timely way. This review should consider not only officer capacity but whether additional training on the PTR requirements should be undertaken.

39. I am pleased to note that in commenting on the draft of this report **Powys Teaching Health Board** has agreed to implement these recommendations.

Nick Bennett 22 October 2020
Ombudsman

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