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PUBLIC SERVICES OMBUDSMAN FOR WALES

The investigation of a complaint against Hywel Dda University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202002558

Contents

Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

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 Ms B.

Summary

Ms B complained that Hywel Dda University Health Board ("the Health Board") failed to provide appropriate care to her son, Mr C. Specifically, Ms B complained that the Health Board failed to provide Mr C with appropriate psychology services and as a result failed to meet his clinical needs.

The Ombudsman upheld Ms B's complaint. He found that the Health Board failed to take prompt steps and make arrangements to meet the clinical needs of Mr C following the closure of a psychology service. Despite the Health Board identifying that Mr C's needs were not being met, it failed to put any plan in place to meet those needs. He found that Ms B, as Mr C's main carer, was left without sufficient support to manage his challenging behaviours. This was at a time when Mr C's challenging behaviours were further complicated by the impact of the restrictions due to the COVID-19 lockdown. He found no evidence of contingency planning should the psychology service come to an end, meaning that the Health Board and the patients receiving the psychology service were unprepared for the abrupt end.

The Ombudsman found that the Health Board's communication with Ms B was inadequate which left her uninformed at the time of the COVID-19 lockdown when she was struggling to cope with Mr C's challenging behaviours. He also found that the Health Board's complaint responses to Ms B were inadequate and were not in line with the relevant regulations.

The Ombudsman recommended that the Health Board:

a) Provide Ms B with a written apology for the clinical, communication and complaint handling failings identified in his report. This apology should refer to the impact of the failings on both Mr C and his family.

b) Remind the relevant staff of the importance of investigating complaints and producing complaint responses in line with relevant complaint regulations and guidance.

c) Undertakes a review to identify any other patients with unmet clinical needs as a result of the closure of the Specialist Service and ensures that steps are being taken to meet those needs either by the Health Board or other agencies.

d) Commissions and completes its planned review of the Health Board's child psychology services and reports the findings back to the Ombudsman.

The complaint

1. Ms B complained that Hywel Dda University Health Board ("the Health Board") failed to provide appropriate care to her son, Mr C. Specifically, Ms B complained that the Health Board failed to provide Mr C with appropriate psychology services and as a result failed to meet his clinical needs.

Investigation

2. My Investigation Officer obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Ms B. The investigation did not consider the actions of the Council or Social Services.

3. Clinical advice was obtained from a Consultant Clinical Psychologist ("the Adviser"), Dr Paul Abeles. The Adviser was asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. I determine whether the standard of care was appropriate by referring to relevant national standards or regulatory, professional, or statutory guidance which applied at the time of the events.

4. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

5. Both Ms B and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant legislation and guidance

6. The National Institute for Health and Care Excellence ("NICE") Guideline NG93: Learning disabilities and behaviour that challenges: service design and delivery (published March 2018) and NICE Guideline NG11: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (published May 2015) ("the NICE Guidelines").

7. The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the PTR Regulations"). The PTR Regulations underpin the arrangements for the handling of concerns in the NHS and set out that people should receive a detailed response to their concerns, including clarity about next steps and actions to address their concern.

8. The Welsh Government has issued statutory guidance on NHS complaints handling. Under the Putting Things Right Guidance ("the PTR Guidance"), Health Bodies are expected to deal with concerns openly and honestly.

Background events

9. At the time of events complained about, Mr C was 17 years old, and Ms B was his main carer. Mr C is severely autistic, non-verbal and displays challenging behaviour.

10. From March **2019** Mr C received a range of psychology services from the Health Board's Specialist Learning Disability Psychology and Behaviour Service for Children and Young People with Behaviour that Challenges ("the Specialist Service").

11. Through the Specialist Service both Mr C and his family were able to access psychologists and psychiatrists to support with Mr C's behavioural issues. This included help and support for Ms B with how to manage Mr C's behaviour and specific suggestions of both preventative and reactive actions that could be taken to address the challenging behaviour displayed.

12. From 22 October the Specialist Service stopped providing services to Mr C.

13. In December the Specialist Service stopped providing services to all patients in the Health Board because of staff departures and a loss of funding. The Specialist Service was not replaced by the Health Board. The Health Board carried out a risk assessment ("the Risk Assessment") which noted that the Specialist Service had closed and there was a need

for permanent and sustainable resources to be identified. It was noted that there were 3 individuals with an ongoing need that were 18 or nearing the age of 18.

14. On 25 February **2020** Ms B complained to the Health Board about the lack of provision in learning disability support for Mr C. Ms B explained that she had been unable to access support from the Specialist Service and noted that due to Mr C's complex needs, psychological support was vital to understand what was happening with him and to find practical ways to deal with him. Ms B noted that this was an urgent need and the situation was, from her perspective, desperate.

15. On 28 February the Health Board's Head of Learning Disability Psychology and Behavioural Services ("the Consultant Clinical Psychologist") noted in an internal email, that while the Specialist Service needed to be considered at senior management level for determination of strategic and sustainable provision, it needed to be emphasised that the closure of the service meant that children and families had lost a service which they may have relied upon for many years.

16. The Consultant Clinical Psychologist wrote to Ms B on 22 April in response to her concerns. The Consultant Clinical Psychologist said she was keen to consider ways in which the Health Board could offer support to Mr C. The Consultant Clinical Psychologist noted that given Mr C's age she would expect a transition plan to be in place for the transition between child and adult services. The Consultant Clinical Psychologist also said that she would look into the psychology services available in the Health Board's area and would discuss what support could be provided to both Ms B and Mr C.

17. Ms B wrote to the Health Board again on 11 August and raised concerns that she had received "virtually no response" to the complaint she had raised. Ms B noted that no way forward had been identified and no plan of action had been communicated to her. She explained that Mr C and her family were in profound crisis.

18. On 12 August the Consultant Clinical Psychologist responded to Ms B's further concerns. She explained that Mr C's situation had been raised as an unmet clinical need within the Health Board. The Consultant Clinical Psychologist explained that a remote meeting was taking place with the Adult Community Team for Learning Disabilities to ensure a smooth transition between child and adult services for Mr C. The Consultant Clinical Psychologist noted that this did not replace the Specialist Service for Mr C and he had a clinical need which was still not being met.

19. On 16 August Mr C displayed challenging and violent behaviour and Ms B contacted the Police. Mr C was subsequently taken to Glangwili Hospital's Emergency Department ("the ED"). Mr C was assessed in the ED and referred to the Health Board's Child and Adolescent Mental Health Services ("CAMHS").

20. On 20 August Mr C was assessed by the CAMHS Crisis Assessment and Treatment Team. The assessment was carried out by a Clinical Psychologist ("the CAMHS Psychologist") and a mental health nurse. The CAMHS Psychologist noted that Mr C displayed challenging behaviour in the form of kicking, scratching, punching and throwing items. It was documented that Mr C's behaviour was often directed at his parents and in particular, towards Ms B. The CAMHS Psychologist documented that the transition process for Mr C moving to the Community Team Learning Disability ("the CTLD") should be underway and in order to facilitate a transition to adult CTLD, it would be useful for agencies supporting him to meet and develop a plan on how best to support him. She also noted that Mr C required a further assessment of his sensory needs and consideration of regular respite provision.

Ms B's evidence

21. In her complaint to the Health Board, Ms B noted the significant impact in the closure of the Specialist Service. She explained that she was on the brink of not being able to cope with Mr C due to his extremely complex and extremely unco-operative behaviours. Ms B explained that psychological support was key to understanding what was going on with Mr C and finding practical ways to deal with him.

22. In her complaint to my office, Ms B said that she is the main carer of Mr C who is severely autistic, and non-verbal. Ms B said that the ending of the Specialist Service left a huge gap for herself and all families with children with learning disabilities in the Health Board's area.

23. Ms B said that the Health Board failed to meet Mr C's clinical needs and contravened national guidelines. Ms B said that the Specialist Service was very important for Mr C and enabled him to access psychologists and psychiatrists for support with behavioural issues and provide her with support.

24. Ms B said that she was told by the Health Board that Mr C could not access the essential psychology services he needed, which he had previously received from the Specialist Service, until he was 18 and not before. Ms C said that she did not believe the Health Board's solution to wait until Mr C turned 18 was appropriate.

25. Ms B said that she asked the Health Board for specialist advice and support, but none was forthcoming because there was no Specialist Service within the entire Health Board area for children and young people aged under 18. Ms B said that she was left "begging" for support for months and was left on the verge of having to put Mr C into care.

26. Ms B said that when the Specialist Service ended, Mr C displayed difficult and violent behaviour. Ms B said that Mr C's behaviour reached a crisis point in August 2020 which led to the involvement of police, specialist CAMHS and emergency social services. Ms B said that her family had been destroyed and they had to endure months of very difficult and violent behaviour from Mr C. Ms B said that Mr C has harmed himself and has harmed her. Ms B said that Mr C was left without specialist support and previously, in times of crisis he was able to access vital support from a consultant psychologist in the Specialist Service and it was always very helpful in dealing and managing his crisis.

27. Ms C said that she was very concerned that there was no Specialist Service for all children in the Health Board's area and she did not want other families to go through what she and her family had experienced. Ms C said that there had been no urgency on the part of the Health Board to replace the Specialist Service and this had left her devastated.

28. Ms B said that there was very little communication from the Health Board and when it did communicate, it acknowledged the problem but did not provide any solution to it.

The Health Board's evidence

29. In its communications with my Investigation Officer, the Health Board said that it had comprehensively reviewed the circumstances and acknowledged there was much truth in what Ms B was asserting; it said that this was very unfortunate and distressing. The Health Board said that the Specialist Service was a clinical need for Mr C and therefore, the lack of service resulted in Mr C having an unmet clinical need.

30. The Health Board said that following the ending of the Specialist Service, Mr C continued to receive support from the Local Authority, education service and paediatrics.

31. The Health Board said that the relevant guidance for the Specialist Service, the NICE Guidelines, did not specifically state who should be the provider of the services and said that it was a multi-agency responsibility with other support being provided by the Local Authority and education services. The Health Board also noted that Ms B received support from a CAMHS clinical psychologist during this time.

32. The Health Board said that it was unable to provide my Investigation Officer with certain relevant documentation because of the absence of a number of relevant staff. The Health Board also said that the long-term absence of some clinical staff members contributed to its inability to provide a psychology service to Mr C.

33. The Health Board apologised for not managing Ms B's complaint in line with the PTR Guidance.

34. The Health Board has provided evidence, in response to my investigation, of an investigation and report into Children and Young People Health Services across the Health Board. This report set out that the Health Board has established plans to develop multi-agency transition protocols for children and young people with learning disabilities.

Professional Advice

35. The Adviser said that the Consultant Clinical Psychologist outlined, in her complaint response dated 22 April 2020, that she would refer Mr C to an Adult Community Learning Disability team and explore what other local psychology services were available. The Adviser said that the plans set out by the Consultant Clinical Psychologist were appropriate ways to provide for Mr C following the ending of the Specialist Service. He said however, that neither plan was put into place for Mr C. The Adviser said that there was no evidence of any successful follow-through on the suggestions and there was no successful commissioning of alternative arrangements to provide a psychology service for Mr C from a neighbouring health board or provision. The Adviser said that some 4 months after her email outlining the plans, the Consultant Clinical Psychologist noted that no psychology services were available for Mr C, the case was closed to her and there continued to be an unmet clinical need. The Adviser said that instead of any plans being put into place for Mr C, the family's main source of support from the Health Board was from its paediatrics service.

36. The Adviser said that Mr C's needs were not met by the Health Board, in terms of the provision of a psychology service, and his family did not have sufficient support. The Adviser said that there was a requirement to meet Mr C's clinical need particularly because of his escalating and emerging difficulties around challenging behaviours in relation to puberty and the additional challenges of the COVID-19 lockdown. The Adviser said it was likely that Mr C's challenging behaviours increased due to the lack of involvement of the Specialist Service and that those behaviours became even more entrenched.

37. The Adviser said that the Health Board's response to my investigation implied that it was meeting Mr C's needs for psychology services through Mr C's contact with a psychologist in the CAMHS. However, the Adviser

said that this was disingenuous to state as Mr C's involvement with those services only came about because of his crisis and escalation in August 2020 which required an attendance at the ED. The Adviser said therefore that Mr C's contact with the CAMHS Psychologist was not a planned intervention of a psychology service.

38. The Adviser said that the Health Board's delayed response to Ms B's concerns was notable. He added that the response in April 2020 promised various options to meet Mr C's needs, but this was not followed up and there also did not appear to be any timely communication around this with Ms B.

39. The Adviser said that the NICE Guidelines do not specifically state who the provider of the psychology service should be, and in this sense, the Health Board did not contravene the NICE Guidelines. The Adviser said that the Specialist Service was commissioned as a short-term project and closed due to the exit of staff from the service. The Adviser said that the Specialist Service met an immediate clinical need for Mr C that the Health Board should have been acutely aware of, and prompt arrangements were not made to ensure this need was provided for and therefore in this sense, the Health Board failed to deliver.

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

40. The Health Board said it wished to reiterate its apologies to Mr C and his family. The Health Board said that it is a priority of the Health Board to improve the services available to children and young people, particularly in relation to the area of prevention and transition into adult services. The Health Board added that it fully acknowledged and apologised for the poor experience of Mr C and his family and recognised that Ms B had to go to a lot of effort to raise her continued and escalating concerns, which would not have been required had the appropriate communication been in place.

41. The Health Board said that it is committed to ensure that the impact of the Specialist Service is recognised and influences and informs future service delivery. It added that, it is sadly the case that there are challenges in securing the specialist skills of psychology staff.

42. The Health Board said that it is in no doubt that there is a need to continue to provide a dedicated psychological service to children and young people. The Health Board said that it has developed a draft 3-year plan for its children and young people's services which includes a number of different developments. In particular, the 3-year draft plan includes the plan to develop a new integrated service model for children and young people who require behavioural support. In addition, the Health Board said that its 3-year draft plan includes the plan to commission a clinically-led psychology review for children in conjunction with its Community Paediatric Clinic Lead and a consultant psychologist.

Analysis and conclusions

43. In considering Mr B's complaint and in reaching my findings, I have had regard to the advice that I have received from my Adviser, although the conclusions reached are my own.

44. Ms B complained that the Health Board failed to provide appropriate care to her son, Mr C. Specifically, Ms B complained that the Health Board failed to provide Mr C with appropriate psychology services and as a result failed to meet his clinical needs. I **uphold** this complaint.

45. The Health Board were aware that the Specialist Service would stop providing services to all its patients following the loss of funding and staff in December 2019. I consider that because the Specialist Service addressed an identified and immediate clinical need for Mr C, the Health Board should have taken prompt steps and made arrangements to ensure that the clinical needs of Mr C were met. It did not do this, and this is a service failure. Ms B drew to the Health Board's attention that Mr C's challenging behaviours were worsening as a result of puberty and the COVID-19 lockdown and despite identifying that needs were not being met and a plan needed to be put in place to address those needs, the Health Board did not put a plan in place.

46. Ms B, as Mr C's main carer, was left without sufficient support to manage Mr C's challenging behaviours. This was at a time when Mr C's challenging behaviours were further complicated by the impact of the restrictions due to the COVID-19 lockdown. The Adviser also said that

Mr C's challenging behaviours increased due to the lack of involvement of the Specialist Service. In my view, this amounts to a significant injustice to Mr C and his family. Ms B has described how she felt her family had been destroyed and she was left on the verge of putting Mr C into care because of this lack of support.

47. Ms C has also noted that she is concerned about the lack of Specialist Service in the Health Board's area and the impact of this on other families. I share this concern. The Health Board identified, in its Risk Assessment, 3 individuals who were 18 or nearing 18 with identified ongoing needs. It remains unclear how many younger patients were affected and whether the Health Board took any steps to find ways to address the outstanding needs in the cases of all of those other patients.

48. I also consider that the Health Board's communication with Ms B was inadequate. Following the closure of the Specialist Service there is no evidence of any communication from the Health Board to Ms B about how it planned to manage Mr C and meet his clinical needs. Ms B has described how she was left in profound crisis and begging for support for months. Certainly, as a result of the lack of communication, Ms B complained to the Health Board in February 2020. In response to Ms B's complaint, the Health Board advised her of the steps it planned to take following the closure of the Specialist Service, namely to ensure a plan was in place for Mr C's transition into adult services and to explore what other psychology services were available in the Health Board's area. I consider that such plans were appropriate. However, the Health Board failed to follow through with the plans it had outlined and failed to communicate this to Ms B in a timely appropriate manner. This is evidenced by the fact that Ms B had to again write to the Health Board in August 2020 to raise concerns about the lack of service for Mr C and explain that her family were now in profound crisis. I consider that the Health Board should have communicated with Ms B, as Mr C's main carer, about what steps it was taking. Instead, it left Ms B uninformed and at the time of the COVID-19 lockdown, when she was struggling with how to cope with Mr C's challenging behaviours. This was unacceptable and was a significant injustice to Ms B and Mr C.

49. I consider the Health Board's complaint responses to Ms B were also inadequate. Significantly, the Health Board's complaint responses were brief and failed to consider, in line with the PTR Regulations, whether there was any breach of duty on the part of the Health Board. This is unacceptable. I have already drawn this to the attention of the Health Board, and it has acknowledged that it failed to follow a number of aspects of the complaint response process set out by the PTR Regulations. I will make further recommendations in this regard below.

50. Similarly, I am concerned about the Health Board's explanation, to my Investigation Officer, that Mr C received support from a clinical psychologist from CAMHS following the closure of the Specialist Service. The Health Board's response implies that it met Mr C's need for a psychology service in this way. I do not accept this explanation. Mr C's support from CAMHS was not a planned intervention on the part of the Health Board and instead, arose as a result of a serious escalation in Mr C's behaviours which led to his crisis and resultant ED attendance in August 2020. I therefore consider that the Health Board's explanation in this regard was disingenuous. It is particularly concerning given that Ms C raised concerns about the lack of psychology service for Mr C in February and the Health Board did not, in its responses to her, offer Mr C support from CAMHS.

51. I am also concerned about the Health Board's, in my view, unhelpful response, that it had not failed to meet the terms of the NICE Guidelines because they do not say which agency is responsible for providing this type of care. The Health Board said it could be met by a multi-agency approach. Whilst this may be so, until December 2019 the Health Board had assumed responsibility for providing this care through a Specialist Service, and it has not provided any evidence to reflect that it engaged with other agencies to arrange an alternative in the event that the Specialist Service came to an end. Therefore, I do not accept that the Health Board is absolved of the responsibility because the NICE Guidelines say that other agencies could deliver these services.

52. I have seen no evidence of contingency planning should this service come to an end, meaning that the Health Board and the patients receiving the service were unprepared for the abrupt end of the service. Indeed, the

Consultant Clinical Psychologist noted in February, that the ending of the service had left families without access to a service they may have relied upon for a number of years. The Consultant Clinical Psychologist also explained, in her complaint response to Ms B in April, that there was recognition within the Health Board in the importance of early intervention for children and young people and the need for strategic planning for psychology services at a senior management level within the Health Board. However, while the Health Board has investigated and produced a detailed report in September 2020, into Children and Young People Health Services across the Health Board, I do not consider that it adequately considers and addresses the gap in service left by the closure of the Specialist Service, and it does not set out any steps the Health Board is going to take to meet this gap in service.

Recommendations

53. In making my recommendations I have taken into account action the Health Board has evidenced it is taking. I have noted the Health Board's 3-year draft plan for its children and young people's services. In particular, I note the Health Board's draft plan to commission a clinically led review of its child psychology services, and to develop a new integrated service model for children and young people who require behavioural support. In addition, I have noted that the Health Board has set out plans to ensure multi-agency transition protocols are published for children and young people with learning disabilities and I therefore consider that I could not make further recommendations in this regard.

54. Ms B has also expressed her view that she does not want financial redress in response to her complaint and it is for this reason I have not made any recommendation for financial redress.

55. I **recommend** that, within **1 month** of this report being issued the Health Board:

a) Provides Ms B with a written apology for the clinical, communication and complaint handling failings identified in this report. This apology should refer to the impact of the failings on both Mr C and his family.

b) Reminds the relevant staff in the importance of investigating complaints and producing complaint responses in line with the PTR Regulations and Guidance.

56. I further **recommend** that, within **3 months** of this report being issued, the Health Board:

c) Undertakes a review to identify any other patients with an unmet clinical need as a result of the closure of the Specialist Service and ensures that steps are being taken to meet those needs either by the Health Board or other agencies.

57. I further **recommend** that, within **6 months** of this report being issued, the Health Board:

d) Commissions and completes its planned review of the Health Board's child psychology services and reports the findings back to the Ombudsman.

58. I am pleased to note that in commenting on the draft of this report **Hywel Dda University Health Board** has agreed to implement these recommendations.

Nick Bennett 29 September 2021
Ombwdsmon/Ombudsman

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