Health and Social Care Committee

Meeting Venue:
Committee Room 1 - Senedd

Meeting date:
Wednesday, 16 July 2014

Meeting time:
08.45

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:
Llinos Madeley
Committee Clerk
029 2089 8403
HSCCommittee@wales.gov.uk

Agenda

1 Introductions, apologies and substitutions

2 Motion under Standing Order 17.42(vi) to resolve to exclude the public from the meeting for the following business: (08.45)
Item 3

3 Inquiry into progress made to date on implementing the Welsh Government's Cancer Delivery Plan: consideration of the key issues (08.45 - 9.15) (Pages 1 - 11)

Public Meeting (9:15 - 12:30)

4 Inquiry into the NHS complaints process: evidence session 1 (9.15 - 10.00) (Pages 12 - 24)

- Keith Evans, Author of the Report 'A Review of Concerns (Complaints)

Handling in NHS Wales – "Using the Gift of Complaints"'.

Keith Evans's report *A Review of Concerns (Complaints) Handling in NHS Wales – "Using the Gift of Complaints"* was published on 2 July 2014

5 Inquiry into the NHS complaints process: evidence session 2 (10.00 – 10.45) (Pages 25 – 36)

- The Rt Hon Ann Clwyd MP, Co-Chair, Review of the NHS Hospitals Complaints System (NHS England).

(Break – 10.45 – 11.00)

6 Inquiry into the NHS complaints process: evidence session 3 (11.00 – 11.45) (Pages 37 – 42)

- **Rory Farrelly, Director of Nursing and Patient Experience, Abertawe Bro Morgannwg University Health Board**
- **Nicola Williams, Assistant Director of Nursing and Lead on Transformation of Complaints and Concerns, Abertawe Bro Morgannwg University Health Board**
- **Maria Battle, Chair of Cardiff and Vale University Health Board**
- **Dr Chris Jones, Chair of Cwm Taf University Health Board**
- **Carol Shillabeer, Director of Nursing/Deputy Chief Executive, Powys Teaching Health Board**

7 Inquiry into the NHS complaints process: evidence session 4 (11.45 – 12.30) (Pages 43 – 55)

- Dr Phil Banfield, Chairman of BMA Welsh Council
- Tina Donnelly, Director of the Royal College of Nursing Wales
- Jessica Turner, Regional Organiser of UNISON Cymru/Wales

8 Papers to note (12.30) (Pages 56 – 60)

The Committee's forward work programme: September – December 2014 (Pages 61

- 65)

9 Motion under Standing Order 17.42(vi) to resolve to exclude the public from the remainder of the meeting and for item 1 of the meeting on 18 September 2014 (12.30)

10 Inquiry into the NHS complaints process: private consideration of evidence received (12.30 - 12.45)

Agenda Item 3

Document is Restricted

Document is Restricted

NHS COMPLAINTS PROCESS IN WALES

EVIDENCE TO THE INQUIRY OF THE HEALTH AND SOCIAL CARE COMMITTEE OF THE WELSH ASSEMBLY

Rt Hon Ann Clwyd MP

8 July 2014

1. Introduction

My submission to the Committee relies heavily on the insights, analysis and conclusions arrived at during the review of NHS Complaint Handling in the English NHS, which I co-chaired.[1] Generally speaking the evidence available to me suggests that the underlying concerns about the way in which complaints are handled are the same in Wales. There is a similar failure to learn from complaints, and, unsurprisingly, the changes required to go forward are along the same lines as I have recommended in the English context.

The recently published detailed report by Keith Evans arrives at broadly similar conclusions.[2]

Sources: The evidence is qualitative in nature, and largely extracted from the hundreds of letters I received from patients or their relatives who had complaints about the standard of service they received from NHS Wales. Other examples are taken from constituency casework, and from testimony given in person at meetings. In each category below, the examples have been chosen because they are representative of considerable numbers of typical cases. All cases are from Wales, and have been brought to my attention within the last 18 months.

I make important additional reference to the recommendations of the Welsh Ombudsman, whose deliberations reflect markedly the workings of the complaints system, in cases brought to her attention.[3]

It should be noted that I have confined my evidence to the acute sector, which was in turn the remit of my review of the English NHS. I am however acutely aware of the importance of ensuring that the complaints system is effective for the primary care sector

2. The Experience of Using the NHS Complaints System in Wales

Here I provide examples from Wales which illustrate the same themes which I listed in the report of my review "A Review of the NHS Hospitals Complaints System - Putting Patients Back in the Picture" (October 2013).

[1] Rt Hon Ann Clwyd MP and Professor Tricia Hart, *Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture*, Department of Health, 28 October 2013
[2] Keith Evans, *Review of concerns (complaints) handling within NHS Wales – 'Using the gift of complaints',* Welsh Government, 2 July 2014
[3] Professor Margaret Griffiths, *The Ombudsman's Casebook,* Public Services Ombudsman in Wales, Issue 16, May 2014

3. Information and accessibility

Many reported that they could find no information about how to make a comment, ask a question, or complain, and could not access the means to complain if they did. The need for this information often occurred at a stressful time in people's lives when they were not best placed to explore the correct procedure for their complaint.

Information appears not to be available in many wards about the system for complaints or feedback, and it is all too frequently the case that there is confusion about who is in charge of a patient's care.

> *"It took four days for me to get anyone to even speak to me about my dad's care"*
>
> *"No-one was able to advise on how to make a complaint."*

Others felt the present system was inaccessible to all but the most literate and determined, with the onus on the patient or their relative to compose documentation and to supply clinical or technical information. NHS organisations could make it harder to put together a complaint too, by either not keeping proper records or withholding information from complainants.

> *"You only get back what the hospital says has happened. You must identify every part and go through the process. It feels like being smothered, a constant battle."*

Some people who had asked for critical information did not get it:

> *"My mother suffers from Alzheimer's disease. We were informed that a member of staff on the ward had been accused of abusing patients and that an investigation was underway by POVA. This was some time ago and no-one will tell us anything."*

4. Fear of complaining

This is a very strong theme in many letters I have received. Both patients and relatives believe that they will lose the empathy of those who should be caring for them, or that their subsequent treatment will be affected detrimentally if they make a complaint. Patients alone in a hospital bed feel uniquely vulnerable, and dependent on the very staff they wish to complain about. Relatives may feel that complaining may rebound in the attitude towards the patient when they themselves are not at the bedside.

> *"I saw a patient being treated badly (in ITU) but was too afraid to say anything at the time."*
>
> *"My late husband had poor care, and I was questioned by the consultant about why I raised a complaint. After that I was too scared to complain again at the time, for fear of making future treatment more difficult, even though he was given the wrong medication, and had bruises on his arms."*

For some patients their fears seemed justified:

> *"It's dangerous to complain. The fact that I had complained was made visible on all my records."*

5. Insensitivity

All too often the tone and language used in interacting with complainants is felt to be inappropriate or at worst callous and unsympathetic, especially in what may be a stressful time for patients or family members.

> *"The complaints people were not helpful. I felt lower than them – there was a great lack of communication on their part."*
>
> *"The language used in their letters was patronising, condescending and full of platitudes. I felt insulted."*
>
> *"The hospital wrote to me and said that my complaint about my sister's death had "been a learning curve" for the staff involved – no apology."*

6. Unresponsive to issues raised in complaint

Too often too, the response received to a complaint sidestepped or missed the point about which the complaint was originally made.

> *"When you make a complaint, their reply makes you feel you are being smothered by NHS words – it makes you sick."*
>
> *"A nice friendly letter is not enough – you want an explanation about what has happened to someone while they were in their (hospital) care"*
>
> *"Eventually I got a reply – but it completely overlooked the dehydration and malnutrition issues that were the cause of my complaint. I felt I was being fobbed off."*

7. Prompt and clear process

This was an overwhelming message from significant numbers who made contact with me. The process of complaining was not explained to the person complaining, with often unexplained lengthy intervals between stages, and the entire process extending into many months and indeed years in some cases. People said that they were not told what to expect, what kind of investigation would take place by whom, or when they could expect to receive a response.

For bereaved relatives in particular the often protracted process added to their distress, diverted their energy, and disrupted the grieving process.

> *"It's now two and a half months since my letter was sent to the Chief Executive of the Health Board, and I have received no reply whatsoever. This reinforces my belief that we are being treated with contempt for daring to question our treatment."*
>
> *"I wrote to the concerns team on 1st August about the death of (family members) and now on 19th March I have yet to receive a response. I will never give up until my questions are answered."*

"I've been waiting since 6th September for a credible reply to my complaints about my father's treatment. The silence has been deafening. I eventually referred it to the Ombudsman in February"

"Instead of being able to grieve for my husband, I've spent years of my life trying to get the truth about why he died."

8. Seamless service

Where more than one service (e.g. hospital and GP is involved) – typically people find complaining about the interface between primary and acute care a trying experience, with time wasted in assessing who to blame. Inappropriate arrangements for discharge and referral were a common cause for complaint.

"Correspondence about my complaint seemed to go endlessly to and fro between the hospital and the GP – I was worn down in the end and gave up."

9. Support

Patients often want help with complaining, from someone who understands the complex NHS Wales system. Few in Wales seem to be aware of the independent complaints advocacy service, or of any source of advice or guidance on complaining, either at the time of an incident or later. This indicates that not only do hospitals not display information about the service but that they fail to make referrals to it routinely as they should.

Of the very few people who I met who had used the advocacy service, opinion was divided. Some who had tried to use it they found the help provided was limited and not worthwhile, although others said the service was good.

"I'm very angry having raised serious issues about my mother's treatments for years and been fobbed off, but I didn't know about the CHC and the advocacy service and had no help from them"

"Fortunately my son-in-law is a clinician and pursued my concerns about my husband's death assiduously – there was no other expert help."

"I found the advocacy service good – the problem is the NHS!"

10. Effectiveness

Patients want their complaint to have made a difference, and to make sure that others didn't experience the same problems. Many who did complain felt that it resulted in no change for themselves or others, or simply that they were never told if changes had been made as a result of their complain.

"I complained 10 years ago about bad practice in taking blood sugar tests and was told it would never happen again. I went back recently and nothing has changed. I won't go on my own to the clinic anymore."

"I complained to the Ombudsman who upheld my complaint about my mother's death in 2011...and the hospital was told to correct slack procedures, which to date they still haven't done."

"I wasn't asking for money, I just wanted to make sure that no-one else suffered from the same errors. I couldn't believe they were so defensive and uninterested and never found out if anything changed"

11. Independence

Patients are concerned that their complaint is looked at fairly and without bias. In particular they lack confidence in a system where complaints are investigated by the very people involved in the issue that they have complained about.

Many people told me that they felt the system closed ranks on those who complained, and that independent oversight of their complaint was lacking. Against this, the ordinary person felt powerless to get to the truth about what had happened to them or their family member, to the extent that they sometimes felt there was a conspiracy to cover up mistakes and bad practice by medical staff.

Some reported that they were engaged in distressing and lengthy battles over years where Boards denied information and refused to admit mistakes, only to eventually be vindicated by independent clinical opinion from overseas, or the Ombudsman or in some other way. Considerably larger numbers told me that they had fallen by the wayside in similar endeavours, lacking the personal or financial resources to continue their search for answers.

The lack of an independence in the complaints system was *the* major theme emerging from all of the contact I have had with patients and families over the past two years.

"There's now no independent stage in the complaints system in Wales, or the previous good practice being implemented anywhere else to ensure fair play."

"Health Boards seem to be their own judge and jury."

"Doctors club together if there's a complaint against one of them. There's a lot of self-interest for directors and managers too in defending the hospital against a complaint."

"The CHC's are supposed to be independent but they have mixed roles and are far too cosy with the Health Boards in my opinion."

12. Learning from Complaints

It seems clear that NHS Boards have been slow to understand the value of complaints as a means of service improvement, or to set up suitable systems by which Boards can oversee the complaints system and ensure that attention is paid to addressing the causes of complaints. If they had, it is hard to believe there would be such strength of dissatisfaction.

The importance of learning from actual complaints is accentuated by the widely accepted view that considerable numbers of people who want to complain do not. As I have discovered, many people give up pursuing their case at an early stage, having lost faith in the system.

Perhaps the most telling recent evidence of the failure to learn from complaints is to be found in the reports of the Welsh Ombudsman. There was an 11% increase in the number of complaints against NHS Health Boards and Trusts, in 2013/14 which is noteworthy, and should in itself be taken seriously.

Discounting those "premature" complaints which are referred back to Boards, the very fact that cases have reached the Ombudsman, points to the failure of the complaints system at its local stage to provide both a satisfactory response to the complaint, and crucially to its failure to address the underlying policy and practice concerns which have given rise to it.

The Ombudsman's recommendations in upheld cases represent a devastating indictment of the failure of Health Boards to both handle complaints, as they are supposed to, and to use the complaints system to identify the most serious of clinical, nursing and management system failures.

All of the recommendations below have resulted from complaints which had already been through the complaints systems of the Health Board concerned. It must be assumed that the Health Boards had failed in investigating the matter to acknowledge the shortcomings which the Ombudsman's robust recommendations demand be addressed.

Furthermore, for the Ombudsman to have mounted an investigation, the complaint is unlikely to have been capable of "informal resolution", since the Health Board concerned had not been prepared to acknowledge poor service and issue an apology.

In the attached Appendix, I have listed a sample of the Ombudsman's recommendations in order to convey the gravity of the matters which Health Boards' own complaints systems appears to have failed to identify and address, and which it was left to Ombudsman to expose.

I have not provided the full details of each case, as these can be accessed easily elsewhere. I have however provided a list of recommendations from recent cases, organised by Health Board. These have been compiled from the Ombudsman's Casebook, for the final quarter of 2013/14.

Patients and the public will quite rightly question the value of a complaints system in which it is left to the Ombudsman to recommend that such elementary steps be taken, and to identify a learning opportunity apparently rejected by the Health Board concerned, exposing future patients to risk.

13. Next steps

It is clear that radical reform is required in the way in which complaints are handled in NHS Wales. How NHS Wales responds in detail to this challenge is a matter for others, but I would suggest that any thoroughgoing reform should conform to the following principles:

- Patients should be provided with every opportunity to comment and complain about the services they receive, in whatever way they find it easiest to communicate
- Openness to complaints – everything should be done to make it clear that comments and complaints are welcomed, and that they can be made without fear.
- Those who comment or complain should be kept in touch with what is happening to their comment, concern or complaint, and be told what will change as a result of it. There must be effective, timely, and sensitive communication in particular with those making serious complaints.
- Support and advocacy for those who complain must be provided from a source which has no conflicting interest in the Board complained of.

- The public should be consulted with and involved in any redesign of the complaints system.
- Health Boards and their managers, professional bodies and regulators must review their attitude to complaints by both by patients and whistleblowers, taking advantage of the learning opportunities these present, and creating a positive culture around complaints as a means of service improvement.
- Independence should be a key element in any reform of the complaints system in Wales. This needs to be ensured at every level, and what was lost in the 2011 reforms needs to be restored in this regard. This is most problematic in a small nation, with a similarly small medical and managerial community, but cannot be overlooked.
- The complaints system should form a central plank of the NHS Wales regulatory system, with the aim of guaranteeing common standards and application of national guidelines in complaints handling. As HIW is in itself in the process of reform, I would strongly support the suggestion made by Keith Evans for the appointment of an Independent Complaints Regulator for NHS Wales in the shorter term. The Regulator should be appointed as a matter of some urgency, and have the teeth required to drive change.

APPENDIX

Abertawe Bro Morgannwg University Health Board

The Ombudsman recommended that the Health Board should:

- remind the relevant staff of the importance of good record keeping;
- remind the relevant clinicians of the importance of fully documenting assessments and reviews in the medical records;
- remind all staff of the need to ensure that patient's fluid levels are adequately monitored;
- provide refresher training for the relevant staff on dehydration and when to initiate fluid monitoring;
- ensure adequate blankets are available to all patients within the First Hospital;
- consider how Consultant care is impaired by the current weekend working arrangements, and provide evidence of what consideration has been given to resolve the matter;
- review the failings identified in a report with the clinicians involved in a patient's care and discuss them as part of their professional development/appraisal process;
- share the Ombudsman's report with nursing staff who were involved in Mr X's care and with senior SAU staff, so they are aware of the lessons to be learned from it;
- undertake a review of the current triage/early warning system to ensure it is working appropriately;
- ensure that nurses working in the SAU are trained in the use of the triage system;
- identify criteria for the skills and level of experience required by nurses before they can undertake the triage role;
- review the Royal College of Physicians' Acute Medical Task Force 2007 report to ensure that its recommendations have been implemented;
- issue a reminder about the need for a Consultant review within 24 hours of both acute admissions and transfers on from the AU towards;
- issue a reminder to junior doctors about the availability of on-call Consultants and their general availability for advice at the weekend;
- review the Stroke Policy.

Aneurin Bevan Health Board

The Ombudsman recommended that the Health Board should:

- formally remind the Cardiology Directorate of the Annual Leave Policy;
- formally instruct Cardiology Directorate clinicians of the requirement to ensure that onward referrals to other services, including tertiary care and the Specialist Hospital are dealt with promptly (in line with the Waiting Time Guidance);
- complete an independent audit of first 100 inbound referrals received by the Cardiology Directorate (excluding those to a named cardiologist) since 1 February 2014. The audit to identify whether there has been any similar failing to arrange necessary diagnostics (e.g. echocardiography). If indicated by the outcome of the audit, the process used by the Cardiology Directorate for dealing with inbound referrals should be revised and all relevant staff should be informed of the revised process;
- complete an independent audit of the first 50 onward referrals made by the Cardiology Directorate to other departments/ hospitals since 1 February 2014. The

audit to identify the routine time taken between the decision to make a referral and the referral being sent. If the audit identifies unreasonable delays, the process used by the Cardiology Directorate for making onward referrals is to be revised and all relevant staff should be informed of the revised process;
- discuss the Ombudsman's report and the results of both audits at the next meeting of the Cardiology Directorate's management team;
- provide evidence to this office that all the above recommendations have been completed.
- review its failure to diagnose heart failure with clinicians.

Betsi Cadwaladr University Health Board

***The Ombudsman recommended that the Health Board should*:**

- introduce additional guidance to medical staff to increase their awareness of national guidelines along with the specific need for arterial blood gas analysis in patients with respiratory disease presenting as an emergency with shortness of breath;
- review the ED arrangements for analgesia and of handover processes – copies of new protocol documents to be provided to the Ombudsman in both instances;
- undertake a governance review within 3 months of nursing professional standards covering assessments, physiological and pain monitoring, record keeping and onward transmission documents between the ED and other clinical environments. Evidence of that review to be provided to the Ombudsman within 2 months thereafter;
- to review its (over restrictive) approach to investigating concerns and complaints about primary care, and to update its written procedures on this issue;
- remind staff of the General Medical Council consent guidance and the importance of keeping records of discussions with patients;
- ensure that clinicians are reminded of the importance of patient involvement in the management of their care and treatment, and also of the need to perform further biopsies and seek specialist advice in cases where tests have shown conflicting results;
- as part of a wider learning process, discuss with the members of the UGI MDT involved in Mr A's care, consider the issues raised in this case and the learning points that arise;
- discuss the contents of a report at an appropriate consultant forum across the Health Board;
- share a copy of a serious complaint report with the Chairman of the Health Board;
- carry out a root cause analysis of the failings in respect of complaint handling identified and provide its findings to the Ombudsman;
- provide evidence of the random spot checks carried out to ensure compliance with its procedure for urine analysis on removal of catheter; and provide evidence of the training it has already organised, together with details of how it proposes to ensure that such training forms part of the ongoing development of all relevant staff;
- issue a reminder to staff on the Ward of the importance of good record keeping and the need to ensure that fluid balance charts contain all necessary information. This should form part of the training that the Health Board has already organised;
- carry out a feasibility study into the use of bladder scanners for all urology patients following catheter removal;
- demonstrate that it has in place an appropriate risk assessment procedure which ensures that urological patients being treated on a general ward are appropriately prioritised for transfer to a specialist urology ward where possible;

- review the conflicting anti-coagulation regimes recommended by the operating surgeon and the anti-coagulation clinic and, in light of the clinically significant differences between the two approaches, ensure that recognised good practice (with reference to any applicable guidance) is consistently followed by all relevant staff;
- ensure that it has a procedure in place so that recommendations from the anticoagulation clinic for post-operative care are brought to the attention of the operating surgeon pre-operatively and where differing approaches arise, the rationale for preferring one over the other is discussed and clearly documented in the patient record;
- provide the Ombudsman with evidence that it has reviewed the effectiveness of the changes it has made in relation to pain and manual handling assessments;
- remind its radiologists of the need for clarity in reports where a fracture has occurred at or around the site of a previous fracture;
- provide the Ombudsman with evidence that it has implemented National Patient Safety Alert 16 and in particular that it has satisfactory systems in place to ensure that requesting clinical teams are made aware of radiology reports

Cardiff and the Vale University Health Board

The Ombudsman recommended that the Health Board should:

- Apologise to complainants for its complaints handling failures, and make compensatory payments for time spent in pursuing the complaint;
- Review its arrangements in respect of post-admission medication reconciliation and ensure that a systematic medicine reconciliation programme is in place;
- Ensure that staff training in respect of recognising acute stroke is up to date, with particular reference to the 2012 Stroke Guidelines issued by the Royal College of Physicians;
- Ensure that use of the Rosier score system (or a similarly recognised tool), in order to identify patients who are likely to have had an acute stroke, is implemented;
- With particular reference to the current Stroke Guidelines and NICE guidance, review its arrangements for the identification and treatment of acute stroke and consider including the following measures:
- Ensure that
    a) All patients who may have had an acute stroke (i.e. have been assessed as having a positive Rosier score) should be immediately assessed by a physician trained in stroke medicine to determine whether thrombolysis is suitable;
    b) Suitable patients should have immediate CT scanning and, in all cases, within one hour;
    c) All patients who may have had an acute stroke should be admitted immediately to a specialist acute stroke unit;
    d) All patients who may have had an acute stroke should have a swallowing screening test, using a validated tool, by a trained professional within four hours.
- Review the findings set out in its various complaint responses to Mrs X and to this office and take action to ensure that its own complaints investigations are in accordance with the Putting Things Right scheme, are sufficiently robust, demonstrably independent and, where appropriate, critical of identifiably poor care, which should include the introduction of a quality assurance audit of a sample of its completed complaint investigations;
- remind relevant clinicians of the importance of obtaining serial radiographs in patients who have sustained fractures until such time as the fracture has been demonstrated

to have united on x-ray, particularly in the situation in which the patient is not improving as one would expect;
- conduct an audit of obstetric discharge letters following second trimester pregnancy loss to confirm that they are routinely sent, and contain relevant information.
- formally remind staff members to record the provision of oral care consistently;
- consider introducing specific oral assessment and care planning documentation;
- formally remind staff members to complete and record NGT positional checks;
- formally remind staff members to complete fluid charts;
- arrange to complete random audits of its Intentional Rounding Scheme documentation;
- introduce a care pathway for the investigation of persistent breathing difficulties with an unconfirmed diagnosis;
- share a report of an investigation with all staff involved in the Health Board's consideration of a complaint, to ensure that they are aware of the need to comply with the statutory guidance;
- formally instruct the staff involved in considering and investigating a complaint that they must ensure that, when a complaint involves an allegation of negligence or harm, the investigation report and final response must comply with statutory guidance;
- formally instruct the nursing and clinical staff involved in a case to follow the relevant record keeping guidance;
- provide the Ombudsman with evidence of the systems it has put place to monitor the impact of the actions it has taken, or is taking, to address the communication failings identified in handling a complaint to the Health Board;
- provide the Older People's Commissioner for Wales's report entitled: "Dignified Care?" to all staff;
- that admission clerking proforma and medication charts include a formal DVT risk assessment tool;
- that regular audits should be carried out in relation to DVT prevention;
- that the Health Board should reflect on its complaints handling to ensure that it is sufficiently robust and independent;
- that the Health Board should remind staff of the importance of good record keeping;
- that the Health Board should consider a report as part of the Consultant Physician's next appraisal;
- Apologise for taking a year to respond to a complaint.

Cwm Taf Health Board

The Ombudsman recommended that the Health Board should:

- review its procedure and provision for emergency feeding outside the times of its usual Dietetic Service;
- provide the Ombudsman with evidence of an analysis of a patient's care, any action points and the outcome of the same;
- provide a copy of the final report of an investigation to all the staff involved with Y's care for reflection;
- ensure that it keeps records of all complaint-related meetings;
- ensure that its management of hip fractures complies with relevant guidance;
- provide training related to its Falls Procedure;
- highlight to a Registrar the importance of recording patient's symptoms;
- review the policy of administrating warfarin in preference to low molecular weight heparin;

- Within two months of this report, the Health Board should forward the Orthopaedic Department's policy for the prevention of DVT in long term immobile patients including those in the community.

Hywel Dda Health Board

The Ombudsman recommended that the Health Board should:

- complete an audit of all discharges from the Ward on which a complainant was cared for, which have been completed within the last two months; the audit should analyse whether the failings identified by the Ombudsman are still apparent and, if so, then the Health Board should implement refresher training for all ward staff (including physiotherapy staff if appropriate);
- complete an audit of student physiotherapy record-keeping from the last three months, to analyse whether the failings in physiotherapy record-keeping identified by this report, are still apparent; if so, the Health Board should implement refresher training for all physiotherapy staff (including qualified staff if appropriate);
- complete an audit of all final complaint response letters issued within the last month, to identify complainants have been properly advised of how to take their complaint further if they remain dissatisfied; if the audit identifies similar failings to those found by this investigation, the Health Board should contact those complainants to give them an apology and correct advice;
- audit the use of the risk assessment form for acute surgical admissions and the recording of the reasons where preventative measures were not prescribed;
- to ensure systems were in place to monitor at ward level, compliance with local and national standards on safe medicine management and to make sure that patients with Parkinson's disease were given their usual medication, which could be outside the usual drugs round;
- to audit the completion of fluid intake charts and their accuracy.

THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG CYMRU

Briefing for:	National Assembly for Wales Health and Social Care Committee.
Purpose:	The Welsh NHS Confederation response to the Inquiry into the NHS Complaints Process in Wales
Contact:	Nesta Lloyd – Jones, Policy and Public Affairs Officer, Welsh NHS Confederation **Nesta.lloyd-jones@welshconfed.org** Tel: 02920 349857
Date created:	8 July 2014.

Introduction

1. The Welsh NHS Confederation, on behalf of its members, wholeheartedly welcomes the opportunity to respond to the inquiry into the NHS Complaints Process in Wales following the report on the Review of Concerns (Complaints) Handling within NHS Wales – 'Using the gift of complaints', led by Mr Keith Evans.

2. By representing the seven Health Boards and three NHS Trusts in Wales, the Welsh NHS Confederation brings together the full range of organisations that make up the modern NHS in Wales. Our aim is to reflect the different perspectives as well as the common views of the organisations we represent.

3. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work. Members' involvement underpins all our various activities and we are pleased to have all Local Health Boards and NHS Trusts in Wales as our members.

4. The Welsh NHS Confederation and its members are committed to working with the Welsh Government and its partners to ensure there is a strong NHS which delivers high quality services to the people of Wales.

5. The NHS in Wales has engaged with the Review from the start and Local Health Boards and NHS Trusts in Wales have already begun to consider, and implement, many of the recommendations highlighted within the 'Using the gift of complaints' report.

Summary

6. Patients' expectations of the NHS are growing. It is not only about whether their treatment worked or how long they had to wait, but how they were cared for by staff, how they were spoken to and how comfortable they were made to feel. In an age of rising expectations among the public, it is a critical issue for healthcare providers and something that the NHS must get right.

7. Patients in Wales come into contact with the NHS more than 22 million times each year. A recent survey showed that 94% of patients were satisfied with the overall care they received and 97% of patients in Wales say they were treated with dignity and respect when using hospital services.[i] At the same time, as Keith Evans' Review highlights, there is always room for

improvement and there is no doubt that there are areas where more can be done. The Local Health Boards and NHS Trusts are doing more and more to encourage feedback from patients, their families and their carers to make sure they are getting these things right, and treating patients and their families in the way they should expect.

8. Effective feedback and complaints systems are an integral part of an open and transparent culture in the NHS. The complaints process within the NHS has become more accessible and complaints should be, and generally are, seen by the NHS in Wales as an opportunity to improve services. Whilst the Review provides a range of recommendations, and our members recognise that they need to do better in ensuring effective complaints systems, NHS organisations across Wales have already started to introduce innovative schemes and processes to make sure that frontline staff have a customer-focused approach in their interaction with patients and that patients and their families are aware of how to make a complaint.

9. New schemes or approaches have been introduced across the NHS in Wales, but there is always room for improvement. The NHS in Wales knows that more can still be done to improve the patient's experience of using their services and the recommendations within the report will support this process. It is vital that the NHS in Wales has appropriate checks and procedures in place to investigate complaints and adopt an open culture within which staff, patients, families and the public feel supported to raise concerns.

The complaints process

10. The NHS in Wales agrees that patients, and their family members, must feel supported and empowered to raise any concerns in the first instance, and then throughout the ongoing complaints process. People need to know where to turn when things don't happen as they should, without worrying about feeling awkward or having to battle against an organisation which may have taken a defensive stance.

11. As the Review highlights, 'The Putting Things Right' scheme, introduced in 2011, has been successful in making the NHS take more responsibility for its actions and outcomes. The process is more transparent and accountable than previously and this must continue to enable people to raise their concerns and complaints. The NHS in Wales recognises that more needs to be done to ensure the complaints process is more visible, consistent and standardised across Wales, which will support and empower patients and their families through the complaints process.

12. As the Review highlights, many patients and their families do not want to make a complaint because they feel that if they complain their care will be worse in future. For people dealing with serious health issues or who have been bereaved, the challenges of finding out how to complain can be so great that they give up.[ii] The Review highlights that patients and their family want clear and simple information about how to complain, the complaints process should be easy to navigate and the response provided by the Local Health Board / Trust is tailored to the issue they are complaining about.

13. Whilst the Review indicates some organisations are not always open, and this leads to needless and repetitive complaints, Health Boards and Trusts are actively seeking out the views of patients to ensure that services improve. The all Wales total number for complaints has increased since the introduction of 'The Putting Things Right' scheme, which may demonstrate that patients and their family are more actively engaged with the health service. However,

despite an increase in complaints, it is vital that patients feel supported and NHS staff in Wales feel empowered, and supported, to deal with concerns at source. The NHS is committed to making sure that this is the case at every level, in every part of the service.

Improving services as a result of complaints

14. Patients in Wales come into contact with the NHS more than 22 million times each year. Taking this number into account, it is not surprising that there will be times when patients or their families feel dissatisfied with their care. The number of complaints received by the NHS tend to represent less than 0.1 per cent of all activity. However, although these are small percentages, less than 0.1 percent still represents a large number of people. And for the minority that do experience care that isn't up to the highest quality, those complaints should be considered and service improved as a result of feedback.

15. We agree with Keith Evans that complaints should be seen as a 'gift'. Complaints are an important source of feedback, which can and should be used positively and constructively to improve services. Changing culture and attitudes so that feedback is valued is fundamental to improving services and patients' experiences of care. The seven Health Boards and three NHS Trusts in Wales are committed to improving the way that they handle concerns and to viewing them as an opportunity to improve services. The feedback and experiences, both good and bad, of patients and their families are critical in helping NHS Wales to provide the high standards of care that staff strive to deliver on a daily basis.

16. The vast majority of people tell us they are happy with the care provided and a positive experience is the norm. However, when things don't happen as they should, the NHS in Wales must listen, learn and take action. Complaints should be seen as a welcomed opportunity to help the NHS look at ways of doing things differently to continually improve patient safety and give patients and the public greater confidence in the NHS. Complaints should be recognised as a mechanism that is central to an organisation's wider focus on the quality of care and services it provides. It is crucial that organisations encourage patients, their families and carers, and staff to share their comments and for NHS bodies to act on and learn from feedback. We are working to ensure this good practice is better spread throughout the system.

17. As well as seeing a complaint as a 'gift', we must use the information to change the shape of services. Through enabling a greater focus on issues at the macro level it may help the NHS to understand how our system is not always helping people. For example, from complaints received around caring for frail older people, particularly those with cognitive impairment, it is probably more of a challenge in large District General Hospitals. Our focus as NHS Wales on supporting more care at, or close to, home means that fewer older people with cognitive impairment will need to be admitted. Furthermore we need to change the way in which our environments of care operate for those who do need to come into hospital care, and the NHS has started doing this, for example caring for people with cognitive impairment.

18. In the Welsh NHS Confederation's discussion document 'From Rhetoric to Reality - NHS Wales in 10 years' time'[iii] we referred to building a new understanding of how the NHS should be used, embodied by an agreement with the public that would represent a shared understanding; *'involving the public is central to realising an NHS where patients and the public are key and valued partners, where they are seen as assets'.* The feedback and experiences of patients and families, whether good or bad, are critical so we can make the necessary positive changes in

order to continuously improve and develop our services. The NHS should see complaints as an opportunity to improve the quality of care they provide and support and empower people to raise complaints. Throughout Wales, Health Boards and NHS Trusts are analysing incidents and complaints so that information can be used to improve services.

Transparency and accountability

19. The NHS in Wales has become more transparent and accountable and is further developing a culture of honesty and openness to enable the NHS to learn from mistakes and improve activities. It is essential we deliver a culture of openness and transparency in the context of the whole system. Everyone in the NHS, from ward level to board level, is responsible for improving NHS culture.

20. The need to improve the timeliness and accuracy of data collection is well understood by Chief Executives, Chairs and their Boards. The NHS in Wales recognises that using the information gathered from patients and their families is a vital analytical tool in ensuring that the organisation is not pursuing its own cause and direction when it is not bringing satisfaction to patients. The NHS in Wales agrees with Keith Evans' recommendations relating to improving the availability and consistency of information on a national basis. Increased transparency is a key driver in improving quality across the NHS as a whole, highlighting both those areas where good practice is in place and those where there is scope for improvement. All Health Boards and Trusts are improving visibility and ease of access to information to ensure that patients and the public are informed.

Engaging with patient families

21. We also recognise that the NHS cares not only for the patient but for their family too. Interaction with family members is vital and it is this which the NHS should aim to strengthen further. The lack of information and interaction with families during the care process can, in some circumstances, fuel any issues of general concern and escalate them into a complaint.

22. It is important that the NHS changes the approach it provides to supporting bereaved family members. If the NHS in Wales analysed all the information available around complaints, it is likely that the more serious complaints in the NHS relate to those where a bereavement has occurred. Understanding this and changing the approach in relation to bereavement is essential. Many family members have questions that they need answering rather than wanting to make a complaint. When family members find it difficult to access the consultant or others to help answer those questions they can translate into difficult complaints, hence the need to ensure that people can access appropriate clinicians and managers for information needs. This could also be relevant for other people, as recognised within the Review: *'Trust the opportunity to liaise differently with complainants, patients and communities and find ways in which engagement can operate at a different more inclusive level to learn from those who have had difficult experiences, but who wish to ensure that better outcomes can be achieved through learning'.*

Staff engagement

23. Complaints certainly have their place in the system but this is part of a much wider transformation of culture to enable patients, their families and their carers to feel at ease and supported to raise any concerns they may have. The focus should also be on how to support

staff to raise concerns and make them feel comfortable having both open and honest conversations with patients and acting on the feedback they receive.

24. The NHS in Wales is engaging with the public to show that the complaints will be used by all at every level in an organisation to learn and improve services. We need to do all we can to allow patients who feel they have a grievance to be able to put forward their concerns effectively and simply. At the same time we must not create a climate where staff feel under siege, as this Review has found. When staff see poor practice, they must take action and must be supported to do so. Health Boards/ Trusts must reflect on and respond to what their staff tell them and staff must be supported throughout this process. As the Review highlighted: '*Organisations need to carefully develop an environment built on trust with their own staff. It is important to ensure that your staff members are working in the manner in which you would wish to know that your clients, business partners or users are being treated*'.

Committed to delivering high-quality, patient centred care

25. The NHS in Wales is committed to delivering high quality, patient-centred care. Evidence from healthcare organisations across the world demonstrates that Boards in high performing NHS organisations take this responsibility seriously and continually strive to achieve this, regularly reviewing and examining their performance. By creating a positive organisational culture, they create the right environment to support and enable individual staff (clinical, managerial and support) to do the 'right' thing for patients, their families and carers. High performing organisations:[iv]

- create a positive, open and transparent culture;
- embed desired values and behaviours across the organisation;
- prioritise delivery of high-quality patient care, setting quality objectives;
- have appropriate, integrated governance systems, processes and procedures, including robust clinical and financial governance arrangements, and implement them;
- identify key risks early and work to mitigate them;
- encourage, value and act on feedback from patients and staff;
- understand and track performance, including learning from complaints, concerns and serious incidents to improve the quality of care; and
- know their limitations and understand other organisations may be better equipped to provide some services.

Conclusion

26. We wholeheartedly welcome this important Review by Keith Evans into how concerns and complaints are handled within NHS Wales. While it is important to highlight that the majority of people who receive care and treatment from the NHS in Wales have a positive experience, it is also vital that we recognise this is not always the case for everyone. When care does not meet the high standards which patients and their family deserve and expect, the health service must hold its hands up and make sure action is taken to put things right. In order to do this, the complaints system must be clear, consistent and easy to navigate for patients and their families, who must be reassured that they are being listened to.

27. A good complaints system is vital for accountability and gives the public greater confidence in the NHS. Patients need to be put at the heart of this and not feel sidelined by procedures that have been designed to help them, especially when they in turn are helping to improve the NHS.

[i] Welsh Government, June 2014, Fundamentals of Care audit.
[ii] Healthwatch, November 2013, Improving the health and social care complaints systems.
[iii] The Welsh NHS Confederation, January 2014, From Rhetoric to Reality – NHS Wales in 10 years' time.
[iv] The NHS Confederation, February 2013, Making it better? Assuring high-quality care in the NHS.

Y Gymdeithas Feddygol Brydeinig
British Medical Association
0300 123 1233 bma.org.uk

Pumed Llawr, 2 Pentir Caspian, Ffordd Caspian, Bae Caerdydd, Caerdydd, CF10 4DQ
Fifth Floor, 2 Caspian Point, Caspian Way, Cardiff Bay, Cardiff, CF10 4DQ
T 029 2047 4646

BMA CYMRU WALES

8th July 2014

THE NHS COMPLAINTS PROCESS

National Assembly for Wales
Health and Social Care Committee: Inquiry into the NHS complaints process

Terms of reference: to consider the effectiveness of arrangements for handling complaints in NHS Wales, and what can be learnt from the recent reviews of complaints handling in Wales and England.

RESPONSE:

BMA Cymru Wales welcomes the opportunity to give evidence to the Committees' inquiry into the effectiveness of the NHS complaints process in Wales.

We consider this a very timely inquiry. Due in part to the publication of reviews such as Francis, Berwick, Keogh, Andrews, Evans and others but also due to the fact that concerns about the lack of a clear and effective process – which is responsive, clear, and transparent – is something that our Members have raised with us for quite some time.

In responding to such concerns from members, and as part of our efforts to ensure that we are offering accurate representation, BMA Welsh Council held a recent policy day with doctors from across Wales on the issue of raising and reporting concerns in the workplace for staff and patients. As a result Welsh Council has developed a booklet reflecting what was raised and what Members agreed as recommendations for a way forward. We will be sharing this with members of the Health and Social Care Committee as soon as it is available.

Whilst we have been supportive of the Putting Things Right agenda and continue to support its objectives, it is clear that our members have little confidence in the current process for reporting and handling concerns in NHS Wales. They report that they often feel unable to raise a concern themselves without reproach, and that there is confusion about the method to use and a blurring of responsibility within organisations in responding and handling complaints. They also report that as they move between health boards that different arrangements appear to be in place.

If professionals working within the NHS are confused about the process we can only assume that patients and relatives on the outside and on the receiving end of these services are even more at a loss as where to go for help in raising issues of concern or complaint.

It is apparent that more needs to be done to raise awareness of the Putting Things Right arrangements to the public and to staff. A high number of our GP members report that the PTR process is very secondary care focused and not sufficiently open to primary care professionals.

Community Health Councils certainly need to become more visible to the general public and further empowered in executing their advocacy role. We also believe that there also needs to be greater understanding of responsibilities within organisations, and that such organisations need to take ownership of a complaint as soon as it is made. There also needs to be a consistent approach to this applied across Wales.

Doctors have a clear professional duty to report concerns if they feel that patient safety is at risk. Moreover, they have a responsibility and a pivotal role to play in ensuring that any concern they raise (or are raised with them) are taken seriously and acted upon. Despite this, we know that doctors, particularly junior doctors can be fearful about the personal repercussions of speaking out. The BMA offers members robust guidance on how to go about reporting concerns in the workplace.

An effective complaints process offers enormous potential to contribute to the delivery of effective integrated healthcare in Wales and continual service improvement - through openness, learning and data collection and by the provision of considered and timely feedback. Unfortunately, the current process falls far short of what is required to meet this required objective for both staff and patients.

Moreover *how* complaints are handled is a major contributor to the internal culture of NHS Wales. It is clear that this issue of how a complaint is handled can sometimes break trust to a greater extent than the actual issue at the centre of the complaint.

In this way it is important that 'process' is not the only element to be considered here. While it is important to have a robust policy and framework in place, the matter of how it is applied locally is key to successful delivery. Therefore how staff and patients or their relatives are encouraged and supported to raise concerns, and how they are communicated with, also needs to be part of any review of process or structure.

There is thus both an organisational and an individual element to this.

The report by Keith Evans on concerns and complaints handling[1] made similar reference: "*At the root of many of my reflections will be focusing on some of the basics; for example, despite knowing the importance of communication, hearing examples of getting this wrong both in terms of care and complaint response. It is reassuring to state that in my experience these can and must be addressed, but it requires us to address the customer care environment and culture within the NHS alongside any improvements I suggest to the complaints process"*.

It is clearly apparent that for any process to be effective it requires a culture of no-blame, one which is open and transparent, one with clear patient-centred-leadership and one which provides feedback and focuses on learning as part of the service improvement and efficiency agenda. This should be a routine and everyday part of clinical governance; and not just a matter of compliance. Of course we accept that the current culture is also influenced by other factors – such as pressure to meet short term financial targets, overstretched services and a high number of staffing vacancies.

The Andrews Report[2] spoke of a culture of "*learned-helplessness*" it also said that variation in care resulted from "*an apparent failure to act or provide feedback on reports of problems or incidents*." BMA members have reported similar experiences in Wales: that when they do report concerns that they are not told what has been done in responding to it or in terms of investigation - and that nothing appears to

[1] Evans, Kieth (2014) A review of concerns (complaints) handling in NHS Wales "Using the Gift of Complaints" p4
[2] Andrews, June. (05/2014) 'Trusted to Care' An independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe BroMorgannwg University Health Board, p25.

change. We have heard from members who have been forced to report low-level concerns outside of local processes because those local processes had failed to be responsive.

We have also heard that often after raising concern or reporting a complaint doctors were faced with what they felt was a defensive reaction from managers and were left feeling isolated, powerless and hesitant about raising issues in the future.

Disconnection between staff and managers is a real issue in many areas of service delivery – patients tend to fall between the 'them' and the 'us' of this mentality. This disconnection is a serious barrier to service improvement and therefore to reducing the number of complaints received. Not to mention being financially inefficient. Front line staff should feel empowered to act, respond or escalate concerns raised with them or be confident to raise their own concerns if they need to. The Evans report recognises this well on page 63: "Taking ownership of the complaint is always better than denying it or trying to pass the blame further up or down the line". The report also recognises the unnecessary complexity of management systems and processes in the NHS and suggests several ways of simplifying this in order to streamline how complaints and concerns are dealt with. Healthcare professionals have a duty to be part of bringing this change about; therefore engagement between clinicians and managers is a large part of this agenda and a central requirement of the positive cultural change for which we and many others advocate.

"Using the Gift of Complaints" is a very pertinent title for Keith Evans' recent report. It mirrors our belief that complaints should be seen as opportunities for learning and improvement. Since many complaints can be resolved locally there needs to be a mechanism to capture, learn from and share such experiences and outcomes – ranging from such lower-level concerns up to higher-level complaints. Health boards should welcome and consider (listen and learn) both good and bad feedback, and in this way encourage staff to raise concerns in the workplace.

From a staff-side view our members feel that the current 'whistleblowing' policy is not fit for purpose and undermines the interrelated intentions of Putting Things Right. Subsequently, we believe that greater acknowledgement of the inter-play between staff and patient concerns would help provide a more consistent approach and much needed clarity around process.

Although we have not had opportunity to widely consider the Evans report or recommendations with our membership many of the observations in this report chime with BMA Welsh Councils ongoing work on raising concerns in the workplace and the need for positive cultural change across the NHS in Wales.

We are grateful for the opportunity to contribute to this important inquiry.

Royal College of Nursing evidence to the The National Assembly for Wales's Health and Social Care Committee inquiry into the NHS complaints process.

Terms of reference for the Inquiry

The aim of this work is to seek to inform the Minister's future work on the complaints process in NHS Wales, including how the recommendations of the report on the Review of Concerns (Complaints) Handling within NHS Wales are taken forward.

The terms of reference for this inquiry are to consider the effectiveness of arrangements for handling complaints in NHS Wales, and what can be learnt from the recent reviews of complaints handling in Wales and England.

---

1. The RCN agrees that all complaints need to be received, acknowledged and responded to in an open, transparent and timely manner. Those who complain need to be given clear information about the complaints process, the likely timescales and what access they will be given to the findings of the complaints process. There needs to be greater clarity of what happens with the 'report' that is produced by the NHS organisation in response to the complaint.

2. We must have a system in Wales that emphasises a timely explanation, apology and application of improvements in response to complaints coupled with a culture within the NHS that learns from errors and system failure and is honest, transparent and supportive.

3. Nurses need to be supported in order to manage complaints in an appropriate manner. Handling complaints can be a stressful and difficult irrespective of whether nurses are the subject of a complaint, are receiving a complaint or are supporting patients and carers to make complaints. The Royal College of Nursing is publishing guidance for nurses on Handling Complaints this year.

4. Nurses and Health Care Support Workers have a key role in gathering concerns and complaints from patients, service users and carers. Whilst nurses don't want to react

defensively to complaints sometimes they may feel that they are being disloyal to colleges or their organisation. In some cases nurses may feel that complaints may result in blaming individuals.

5. It is vital that Health Boards create an environment where raising concerns and complaints are regarded as valuable feedback as part of organisational learning and improvement. Directors of Nursing also need to be supported to take an active role in the management of complaints, ensuring that a 'ward to board' approach is adopted across an organisation. Staff need to be reassured at every possible point that pointing out errors or risks and being open is a praiseworthy activity.

6. In April 2013 the RCN published the results of a survey of 8262 nurses across the UK, approximately 65% of nurses in Wales said that they have had to raise concerns about patient safety with their employer. Of the concerns raised, more than half of nurses surveyed in Wales (54 per cent) citing concerns about staffing levels, and 18% were about patient safety. Worryingly, just under half (44 per cent) of nurses in Wales said worries about victimisation or reprisals would make them think twice about whistle blowing with only 34% saying that they would be confident about whistle blowing.

7. Evidence for the last NHS Wales Staff Survey suggests that staff generally feel that they have the opportunity to raise concerns. However, the results of the survey suggest that many staff are unconvinced that appropriate action is taken when concerns are raised. Some RCN members have indicated that they are "discouraged" from raising concerns about unsafe staffing, and are sometimes told not to complete incident reports into such matters. The RCN believes that this issue must be addressed so that patient safety is not compromised.

8. We have called for all healthcare organisations to hold a register of staff concerns that must be reported to their board regularly since 2009 and reiterated this in our response to the Welsh Government's consultation on the Public Services (Workforce) (Wales) Bill 2014.

9. The Welsh Government Regulation and Inspection of Care and Support in Wales proposes that social care providers should be required to produce annual reports to include:

- Evidence about expectations and outcomes for outcomes for users and carers;
- Staff employed and their development
- Records of complaints and action taken – from staff and citizens
- Appropriate financial information.
- Corporate governance arrangements and
- Contingency planning arrangements

The RCN is of the view that healthcare providers should provide the same to the regulators and to ensure that this information is available to the public in a meaningful way.

10. The impact of poor staffing levels and inappropriate skill mix in clinical areas has on patient outcomes is well known. Our Time to Care Campaign launched in 2012 and successive RCN Employments Surveys show a nursing workforce under immense pressure. AN ICM survey for the RCN published in 2013 identified that nurses were spending an estimated 2.5 million hours a week on non-essential paperwork and clerical tasks, more than double the figure in 2008. Eighty one percent of nurses working in every setting surveyed said that having to complete non-essential paperwork prevented them from providing direct patient care.

Nurses are less likely to have sufficient time to develop high quality relationships with patients and to respond to immediate patient concerns, which then may unnecessarily turn into a complaint. It is crucial to ensure that nurses are provided with a working environment that includes:

a) Sufficient numbers, with knowledge and skill of staff so that they are have the time to give the care that they are required to deliver.

b) Protected time in their working week to fulfil their continuous professional development, essential clinical supervision of junior staff and mentoring responsibilities to other nursing staff. (RCN Employment Survey 2013 revealed that

attendance at Mandatory training is lower for nurses in Wales than the rest of UK – e.g. 49.9% in Wales had attended infection control training compared to 68.9% in the rest of the UK).

11. With sufficient time and access to appropriate training nurses are able to spend time with patients and relatives providing both parties with appropriate information about the proposed treatment, care and likely clinical outcomes which will ensure that all parties have realistic expectations of the care and treatment received.

ABOUT THE ROYAL COLLEGE OF NURSING (RCN)

The RCN is the world's largest professional union of nurses, representing over 415,000 nurses, midwives, health visitors, nursing students and health care support workers, including over 24,000 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing.

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

Inquiry into NHS complaints process Briefing
UNISON Cymru Wales
July 2014

The terms of reference for this inquiry are to consider the effectiveness of arrangements for handling complaints in NHS Wales, and what can be learnt from the recent reviews of complaints handling in Wales and England.

Leads: Mr Keith Evans, past CEO Pansonic UK and Ireland & Andrew Goodall, CEO, Anerin Bevan University Health Board

Aims:

- Review the current process to determine what is working well and what needs to improve
- Consider if there is sufficiently clear leadership, accountability and openness
- Identify how the NHS in Wales can learn from other service industries
- Identify how the NHS can demonstrate it is learning from patient feedback

Background:

There have been numerous reports into the NHS complaint procedure. The most important are:

- 2003 - NHS Complaints reform: Making things right
  - Set out Delivering the NHS Plan with the then new Commission for Healthcare Audit and Inspection which aimed to independently scrutinise NHS complaints
  - The improvements aimed to change attitudes to complaints and dealing with them positively as an integral part of the system
- 2004 - Fifth Report of the Shipman inquiry
  - This report was predominately GP focused
  - Recommended that those that make a complaint can lodge it with their local primary care trust instead of their GP
  - PCTs should be able to warn and give financial penalties to GPs
- 2011 - Sixth Report Complaints and Litigation, House of Commons Health Committee
  - Recommended that the Government should have a full review of the "local stage" complaints system
  - The Health Service Ombudsman needs review to expand its remit
  - Patient advice and liaison services (PALS) and independent complaints advocacy services (ICAS) to be promoted more
  - Committee found it is difficult to establish which organisations monitor the NHS
  - Healthwatch need to be more involved
  - Legal complaints must have tighter regulation

- Rejected the recommendation that one single organization should be responsible for maintaining an overview of complaints

- 2012 - Putting Things Right: A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture
  - The overall principles set out in Putting Things Right align very closely with the recommendations made by Robert Francis following the Mid Staffordshire Inquiry

- 2013 - Francis Report
  - A promise to learn – a commitment to act: improving the safety of patients in England
  - Valuing and supporting healthcare assistants
  - A review of the care and treatment provided by 14 hospital trusts in England
  - A review of the NHS hospitals complaints system: putting patients back in the picture
  - Reducing the bureaucratic and regulatory burden on the NHS

- 2013 - Keogh Report
  - It looked at the quality of the care and treatment provided by 14 trusts identified as having higher than average death rates in the two years before the start of the review
  - Eleven of these trusts are to be put under 'special measures' in order to improve governance

- 2013 - Berwick Review into Patient Safety review was conducted after the Francis Report into the problems at Mid Staffordshire Hospitals.
  - The report noted that there was a need for wide systemic change
  - Highlighted that the public should not blame staff, but trust them
  - Recommended against the use of quantitative targets
  - Recognised need for transparency
  - Aimed to attempt to get NHS staff to take pride in their work and give them long term career help

Surveys:

- The National Survey for Wales, published in May 2013 found that 92% of people who saw a GP in the previous 12 months and 92% of people who had a hospital appointment in the same period were "fairly or very satisfied" with the care received.
- CQC research conducted in 2013 found that 15% of patients believe that members of staff were so stretched that complaining wouldn't help
- The medical negligence law firm Fletchers Solicitors found that in 47% of compliant cases, front line staff handled the complaint. Only 26% of complaints went through services managers, despite NHS policy stating that the service provider could be the first port of call.

Key points:

Need to remember that there are two sides: 1) The wellbeing of patients 2) Treatment of staff

Staff who raise concerns are often not listened to and this can lead to poor patient care. The most dangerous thing for patient's safety is staff who are afraid to raise concerns or staff who are afraid to speak up.

UNISON can and will help in this regard.

In a UNISON survey, nursing staff members expressed concern about and a lack of confidence in the DATEX reporting system.

What our members think:

- Sometimes it is hard to get up every day to face complaints
- Majority of us do not feel supported
- Mistakes are going to happen with cost cutting, low staff numbers and sheer size and complexity of the NHS
- The main complaint against staff is that of rudeness
- Most members do not feel that the trusts deal with complaints effectively
- The root cause of the issue needs to be investigated rather than just patching over the issues
- A culture of 'Presumed guilty unless proven otherwise' needs to be changed and we need to get away from a blame culture.
- Investigations take too long to complete. That is not in the interests of patients or staff.
- Staff who get complaints lodged against them get worried and stressed and evitable end up on sick leave.
- There is a need for officers with up to date training in complaints handling.
- The public are more aggressive and less understanding of difficulties primarily due to adverse publicity.
- Not enough emphasis in the media on what we do well, staff feel on the back foot all the time.
- Majority of NHS staff are caring and committed and do not make mistakes, but accept that mistakes or poor care must be addresses.
- Constant attack on the NHS has demoralising and motivating effect on staff.
- Staff generally go above and beyond what are are required to do on a daily basis.
- Managers should listen more to staff about their concerns over patient care.
- There should be more be better communications across departments and wards when things go wrong.

Other issues:

Minimum Staffing Levels:

- A 1:4 staff ratio
- UNISON believe this is one of the major ways of improving the NHS
- This staff ratio should be extended to all staff in all areas of the NHS and not just be confined to hospital settings.

UNISON'S Be Safe Report:

- Following the Francis report, UNISON produced additional guidance for members around raising concerns.
- Our Be Safe form, on which UNISON members and staff can document and submit their concerns to their line manager, was sent out with an accompanying Be Safe credit card-sized leaflet.
- In addition UNISON has developed a Be Safe training programme for our representatives The training equips delegates with the knowledge and confidence to run one- to two-hour workshops in their organisations for all staff (not just UNISON members) on how to raise concerns.

Whistleblowing:

- UNISON wants a change to the whistleblowing legislation to enable groups of staff to raise the same concern and receive the same protection as though they were individuals.
- UNISON supports the need for honesty, openness and transparency in the NHS, as well as a need for greater corporate accountability.
- UNISON believes there are already sufficient checks and balances imposed upon individuals working within the NHS, so imposing additional statutory duties upon individuals (as opposed to organisations) is not necessary
- There is also potential for the duty of candour to be counter-productive: the use of legal sanctions against individuals may serve to reinforce a blame culture and actually prevent a more open and transparent system.

Summary and Recommendations:

There are two aspects to this process, 1) The wellbeing of patients and 2) The Treatment of Staff.

UNISON is fully supportive of any process to improve the complaints process in NHS Wales. We think the process should be less cumbersome, more user friendly, and should support patients, relatives and staff throughout.

We note the impact of bad publicity throughout the service and how such publicity seems to generate more hostility and complaints as patients and relatives almost expect things to be bad when they deal with the NHS.

UNISON would like to make the following recommendations to address the concerns of staff:

- Staff should complete an incident form for all incidents and complaints. Staff should be actively encouraged to do so. There needs to be a consistent approach across all organisations to ensure all incidents are recorded.
- Staff should receive confirmation that their incident reports have been logged and, where appropriate, receive feedback that action has been taken to resolve any issues raised.
- Outcomes should be recorded to ensure that mistakes are not repeated.
- Enhanced partnership working to enable managers and local trade unions to gain greater insight from considering the outcome of events together and where appropriate, staff should be involved in developing solutions to issues raise.
- Mandatory minimum staffing levels
- Change to Whistleblowing legislation
- Address the culture of blame

Agenda Item 8

Health and Social Care Committee

Meeting Venue:	**Committee Room 1 - Senedd**
Meeting date:	**Wednesday, 2 July 2014**
Meeting time:	**09.31 - 11.19**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_200000_02_07_2014&t=0&l=en

Concise Minutes:

Assembly Members:	**David Rees AM (Chair)** **Leighton Andrews AM** **Rebecca Evans AM** **Janet Finch-Saunders AM** **Elin Jones AM** **Darren Millar AM** **Lynne Neagle AM** **Gwyn R Price AM** **Lindsay Whittle AM** **Kirsty Williams AM**
Witnesses:	**Meri Huws, Welsh Language Commissioner** **Rhodri Roberts, Welsh Language Commissioner**
Committee Staff:	**Llinos Madeley (Clerk)** **Helen Finlayson (Second Clerk)** **Sarah Sargent (Deputy Clerk)** **Rhys Iorwerth (Researcher)**

TRANSCRIPT
View the meeting transcript.

1 Introductions, apologies and substitutions

1.1 No apologies were received.

2 General scrutiny session with the Welsh Language Commissioner

2.1 The witnesses responded to questions from Members.

3 Papers to note

3.1 The Committee noted the minutes of the 18 June meeting.

3.1 Letter from the Deputy Minister for Social Services regarding the Social Services and Well-being (Wales) Act – Eligibility Technical Group Report
3.1a The Committee noted the letter from the Deputy Minister for Social Services.

3.2 Letter from the Chair of the Finance Committee
3.2a The Committee noted the letter from the Chair of the Finance Committee.

4 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting

4.1 The motion was agreed.

5 Inquiry into orthodontic services in Wales: consideration of the draft report

5.1 The Committee considered and agreed the draft report, subject to minor changes, for its inquiry into orthodontic services in Wales.

6 Consideration of the Committee's forward work programme: autumn term timetable

6.1 The Committee discussed and agreed its forward work programme for the autumn term.

Health and Social Care Committee

Meeting Venue:	**Committee Room 1 - Senedd**
Meeting date:	**Thursday, 26 June 2014**
Meeting time:	**09.15 - 10.58**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_200000_26_06_2014&t=0&l=en

Concise Minutes:

Assembly Members:	**David Rees AM (Chair)** **Leighton Andrews AM** **Rebecca Evans AM** **Janet Finch-Saunders AM** **Elin Jones AM** **Darren Millar AM** **Lynne Neagle AM** **Gwyn R Price AM** **Lindsay Whittle AM** **Kirsty Williams AM**
Witnesses:	**Mark Drakeford AM, Minister for Health and Social Services** **Grant Duncan, Welsh Government** **Dr Chris Jones, Welsh Government** **Carys Thomas, NISCHR**
Committee Staff:	**Llinos Madeley (Clerk)** **Helen Finlayson (Second Clerk)** **Sarah Sargent (Deputy Clerk)** **Victoria Paris (Researcher)** **Philippa Watkins (Researcher)**

TRANSCRIPT
View the meeting transcript.

1 Introductions, apologies and substitutions

1.1 No apologies were received.

2 Inquiry into progress made to date on implementing the Welsh Government's Cancer Delivery Plan: Evidence session 7

2.1 The Minister responded to questions from Members.
2.2 The Minister agreed to provide the following:

- a note on the delivery of treatment and services for patients with neuroendocrine tumours at an all-Wales level, as an example of services being delivered for the less common cancers;
- confirmation that the technology is in place to support the timely reporting at GP, GP cluster and national levels of the reviews of lung and gastrointestinal cancer cases dealt with by each GP in Wales in 2014;
- a note to update the Committee on the 'trialogue' discussions of the draft EU regulations on data protection, and the potential impact on cancer research in Wales;
- the paper submitted by Public Health Wales to the House of Commons Science and Technology Committee's inquiry into National Health Screening;
- a note on whether there is resource and capacity for bowel scope screening to be provided in Wales.

3 Papers to note

3.1 Members noted the additional information provided by witnesses who attended the Committee's meeting on 8 May 2014 in relation to the inquiry into orthodontic services in Wales.

4 Motion under Standing Order 17.42(vi) to resolve to exclude the public from the remainder of the meeting

4.1 The motion was agreed.

5 Consideration of the Committee's approach to its inquiry into legal highs

5.1 The Committee considered and agreed the approach to its inquiry into new psychoactive substances (“legal highs”).

To: Health and Social Care Committee

From: Policy and Legislation Committee Service

Meeting date: 16 July 2014

Health and Social Care Committee Forward Work Programme: autumn term (September – December 2014)

Purpose

1. This paper invites Members to note the Health and Social Care Committee timetable attached at Annex A.

Background

2. Attached at Annex A is a copy of the Health & Social Care Committee's timetable from September – December 2014.

3. The timetable is published as an aid to Assembly Members and any members of the public who may wish to be aware of the Committee's forward work programme. A document of this kind will be published by the Committee at regular intervals.

4. The timetable is subject to change and may be amended at the Committee's discretion.

Recommendation

5. The Committee is invited to note the work programme at Annex A.

ANNEX A: COMMITTEE TIMETABLE FOR AUTUMN TERM 2014

Thursday 18 September 2014 (morning and afternoon)

- Inquiry into progress made on implementing the Cancer Delivery Plan: consideration of draft report (private)
- Inquiry into access to medical technologies: evidence sessions on primary and social care (public)
- General scrutiny session with the Minister for Health and Social Services and the Deputy Minister for Social Services (public)
- Legislative Consent Memorandum on the Criminal Justice and Courts Bill: consideration of draft report (private)

Wednesday 24 September 2014 (morning only)

- Follow-up to the inquiry into the contribution of community pharmacy to health services in Wales: Ministerial evidence session (public)
- Initial discussion of forward work programme for spring term 2015 (private)
- Briefing to inform the inquiry into new psychoactive substances ("legal highs") (private)

Thursday 2 October 2014 (morning and afternoon)

- Engagement activity to inform the inquiry into new psychoactive substances ("legal highs") (informal)

Wednesday 8 October 2014 (morning only)

- Public Health White Paper: factual briefing from Welsh Government officials (public)
- Post-legislative scrutiny of the Mental Health (Wales) Measure 2010: consideration of written evidence (private)
- Consideration of the Committee's approach to its follow-up work on the inquiries into stillbirths, the prevention of venous-thromboembolism in hospitalised patients, and the implementation of

the National Service Framework for diabetes in Wales and its future direction[1] (private)

Thursday 16 October 2014 (morning and afternoon)

- Inquiry into access to medical technologies: consideration of draft report (private)
- Discussion of forward work programme for spring term 2015 (private)
- Welsh Government's draft budget: Ministerial scrutiny session (public)

Wednesday 22 October 2014 (morning only)

- General scrutiny session with the Chief Medical Officer (public)
- Follow-up to the inquiry into the contribution of community pharmacy to health services in Wales: consideration of draft output (private)
- Welsh Government's draft budget: consideration of draft output (private)

Monday 25 October – Sunday 30 November 2014: recess

Thursday 6 November 2014 (morning and afternoon)

- Inquiry into new psychoactive substances ("legal highs"): oral evidence sessions (public)
- Inquiry into new psychoactive substances ("legal highs"): consideration of evidence (private)

Wednesday 12 November 2014 (morning only)

- Inquiry into new psychoactive substances ("legal highs"): oral evidence sessions (public)
- Inquiry into new psychoactive substances ("legal highs"): consideration of evidence (private)

---

[1] To note, the Committee has written to the Minister for Health and Social Services requesting written updates on progress with the implementation of the Committee's recommendations in order to inform this discussion. These updates will be published in the autumn term once received.

Thursday 20 November 2014 (morning and afternoon)

- General scrutiny of the Chief Medical Officer: consideration of draft output (private)
- Implementation of the Social Services and Well-being (Wales) Act 2014: factual briefing from Welsh Government officials (public) (date TBC)
- Post-legislative scrutiny of Mental Health (Wales) Measure 2010: Ministerial evidence session (public)

Wednesday 26 November 2014 (morning only)

- General scrutiny session with the Older People's Commissioner (public)
- Inquiry into new psychoactive substances ("legal highs"): Ministerial evidence session (public)

Thursday 4 December 2014 (morning and afternoon)

- Business to be confirmed

Wednesday 10 December 2014 (morning only)

- *Minimum Nurse Staffing Levels Bill: consideration of approach to Stage 1 scrutiny*[2] *(private)*
- Post-legislative scrutiny of the Mental Health (Wales) Measure 2010: consideration of draft report (private)
- Inquiry into new psychoactive substances ("legal highs"): consideration of key issues (private)

[2] The deadline for the introduction of this Bill is 3 December 2014. Should the Bill be introduced earlier, this item will be rescheduled accordingly.