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