Y Pwyllgor Iechyd a Gofal Cymdeithasol
Health and Social Care Committee

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Mark Drakeford AM
Minister for Health and Social Services

5 August 2014

Dear Minister

The NHS complaints process in Wales

As you will be aware, we have recently undertaken a short inquiry into the NHS complaints process in Wales. The purpose of our inquiry was to:

- consider the effectiveness of arrangements for handling complaints in NHS Wales;
- consider what can be learnt from the recent reviews of complaints handling in Wales and England; and
- seek to inform your future work on the complaints process in NHS Wales, not least how the recommendations of Mr Keith Evans' report on the review of complaints handling in Wales are taken forward.

From the outset we would like to acknowledge that, in the overwhelming majority of cases, people's experiences of NHS Wales are positive and patients and their relatives are happy with the care they receive. Furthermore, it was clear from the evidence we gathered that people admire and value the NHS, the service it provides and the staff who work within it.

Nevertheless, recent reports such as *Trusted to Care*[1] and *A Review of Concerns (Complaints) Handling in Wales – "Using the Gift of Complaints"* [2]have demonstrated that the way complaints are handled requires significant

---

[1] Professor June Andrews and Mark Butler, *Trusted to Care – An independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board*, 6 May 2014

[2] Keith Evans, *Using the gift of complaints: a review of concerns (complaints) handling in NHS Wales*, June 2014

improvement. With an ageing population, a growth in more complex health problems, and an ever-changing landscape of conditions and treatments, mistakes will occur and lessons will need to be learnt. We therefore recognise the fundamental importance of the recent work undertaken to review complaints handling in Wales and further afield, and welcome the steps that are being taken to help ensure that patients, relatives and staff feel able and well supported to speak out about the smallest or most serious of concerns.

We welcome the assertion made by the Royal College of Nursing (RCN) during our session that there has been a "sea change" in the way the health care community approaches complaints in Wales.[3] It is clear, however, that much work remains if NHS Wales is to meet the standards of transparency, openness and compassion we would expect. It is concerning to us that Mr Evans described a culture of "lockdown"[4] within NHS Wales and a service that is characterised by a sense of defensiveness on the part of those handling complaints and, even more worryingly, fear on the part of those wishing to raise them.[5]

We acknowledge that culture change of the scale required cannot happen overnight. Nevertheless, the recommendations made by Mr Evans in his report provide the building blocks to make the necessary progress. We believe that Mr Evans' recommendations should be considered for implementation as a matter of priority by NHS Wales with progress monitored closely by the Welsh Government.

To inform this work, we have summarised the key issues we believe require further consideration and attention from the Welsh Government and NHS Wales. These are attached in the annex to this letter. We hope the points raised will help deliver progress in this area and we intend to consider the extent to which improvements have been made before the end of this Assembly.

Yours sincerely,

David Rees AM
Chair, Health and Social Care Committee

---

[3] National Assembly for Wales, Health and Social Care Committee, *RoP [para 309]*, 16 July 2014
[4] Ibid, *RoP [para 81]*, 16 July 2014
[5] Ibid, *RoP [paras 22 and 78]*, 16 July 2014

Annex: key issues arising from the inquiry into the NHS complaints process in Wales

Introduction

This annex sets out the key issues which arose during our short inquiry into the NHS complaints process in Wales. It is not an exhaustive list of the issues which were raised during the inquiry – these can be seen in their entirety by accessing the written evidence and the transcript of the oral evidence sessions. The purpose of this annex is to highlight the matters drawn to our attention we believe should be prioritised for further consideration by the Welsh Government and NHS Wales.

Our comments should be read within the context of an NHS in which, in the vast majority of cases, things work well. Nevertheless, the evidence to our inquiry has shown that, in those cases where things do go wrong, complaints are not always handled effectively, and matters of concern to patients, relatives or staff are not always addressed.

1. The role of an independent regulator

Mr Evans told us that most of those to whom he had spoken in the course of his work thought that one of the weaknesses of the *Putting Things Right* framework[6] was insufficient independent regulation.[7] While he believed that in the first instance it was the role of local health boards and trusts to analyse the data relating to incidents, concerns and complaints, investigate the issues and report to the Welsh Government, he was clear that if this did not deliver results, independent regulation should be put in place.[8] The Rt Hon Ann Clwyd MP supported this approach.[9] Local health board representatives accepted that an independent regulator could be helpful, but thought that there needed first to be careful consideration of the recommendations in Mr Evans' report.[10] The report noted that the role of

---

[6] In April 2011 the Welsh Government introduced new arrangements for the management of concerns under the banner *Putting Things Right*

[7] National Assembly for Wales, Health and Social Care Committee, *RoP [para 30]*, 16 July 2014

[8] Ibid, *RoP [para 38]*, 16 July 2014

[9] Ibid, *RoP [para 113]*, 16 July 2014

[10] Ibid, *RoP [para 230]*, 16 July 2014

Healthcare Inspectorate Wales (HIW) in respect of its role in supporting the complaints system should be defined and clarified.[11]

Conclusion 1: We have previously undertaken an inquiry into the work of HIW, following which we recommended that the Minister urgently undertake a fundamental review of HIW to reform, develop and improve its regulatory and inspection functions, with a view to establishing a clear outline of HIW's objectives and core purpose. We were pleased that the Minister accepted our recommendation and commissioned such a review to take place during summer 2014. We believe that this review should also include consideration of the role of HIW in relation to the NHS complaints process. As we outlined in our report of March 2014, we have concerns about the capacity of HIW to undertake its current functions. We agree with Mr Evans' conclusion that, should governance arrangements within health boards and existing regulators prove inadequate, independent regulation of complaints handling should be explored. We therefore recommend that the Minister also considers alternative mechanisms for independent regulation of complaints handling.

2. Community health councils (CHCs)

We heard evidence that there was variability between community health councils in Wales, and a need to strengthen the leadership and ensure that council members were properly trained.[12] Mr Evans told us the CHCs are "the eyes and ears of our health organisations". He said that while the advocacy teams were "excellent, capable people", there was insufficient resourcing, and limited understanding among the public of their role.[13] In his report he said that there was a need for clarity about the respective roles of CHCs, HIW and the Public Services Ombudsman for Wales.[14]

Conclusion 2: In our inquiry into the work of HIW we sought clarification about the role of CHCs. We welcome the work that the Minister has begun on

[11] Keith Evans, *Using the gift of complaints: a review of concerns (complaints) handling in NHS Wales*, recommendation 28, June 2014

[12] National Assembly for Wales, Health and Social Care Committee, *RoP [para 109]*, 16 July 2014

[13] Ibid, *RoP [para 29]*, 16 July 2014

[14] Keith Evans, *Using the gift of complaints: a review of concerns (complaints) handling in NHS Wales*, June 2014

this; however, we are concerned that questions remain about the role played by the organisations charged with representing patients' views. We recommend that the Minister clarify his expectations of the role of CHCs as soon as possible, and that action is taken to ensure better public understanding of this role.

3. Accountability and leadership

Mr Evans' report emphasised the importance of learning from complaints and welcoming the concerns raised by patients and staff as an opportunity to improve services. This view was echoed by other witnesses.[15] Evidence to our inquiry suggested that, in order to ensure lessons are learnt and actions to improve services and prevent repeated poor performance are effectively implemented, strengthened leadership and accountability is needed.[16]

3.1 Local health boards and trusts

In his report, Mr Evans concluded that insufficient resource had been made available to allow for the effective management of *Putting Things Right* at a local and national level, with the result that complainants have sometimes struggled with the process.[17] He also told us that he believed that there was a gap between the complaints process and the chief executives and boards of local health boards and trusts,[18] and that boards needed to ensure that they placed sufficient priority on complaints handling.[19] The Rt Hon Ann Clwyd MP agreed that much of the responsibility for the situation that has arisen in relation to complaints lay with local health board and trust chief executives, chairs and boards.[20] In her evidence she referred to the importance of openness and transparency in the way that boards operate,

---

[15] National Assembly for Wales, Health and Social Care Committee, *RoP [paras 89 and 199]*, 16 July 2014/ *HSC(4)-19-14 Paper 4 Evidence from the British Medical Association Cymru Wales*/ *Paper 5 Evidence from the Royal College of Nursing* / *Paper 3 Evidence from the Welsh NHS Confederation*, 16 July 2014

[16] Ibid, *RoP [para 34]*, 16 July 2014

[17] Keith Evans, *Using the gift of complaints: a review of concerns (complaints) handling in NHS Wales*, June 2014

[18] National Assembly for Wales, Health and Social Care Committee, *RoP [para 24]*, 16 July 2014

[19] Ibid, *RoP [para 56]*, 16 July 2014

[20] Ibid, *RoP [para 146]*, 16 July 2014

the need for training for board chairs and members, and the need for the workings of boards to be communicated accessibly and in plain language.[21] Local health board representatives echoed this, saying that board papers were improving in relation to complaints, but that they needed to be of a better standard, and more widely accessible.[22]

We heard from Mr Evans about the importance of senior leadership involvement in complaints handling.[23] Local health board representatives agreed that this was vital, and described the arrangements in place in their health boards to facilitate this,[24] including:

- co-location of complaints teams with directors, chief executives and chairs;
- ward walking;
- regular meetings with HIW and the Public Services Ombudsman for Wales;
- meetings with complainants; and
- proactively seeking patient and staff feedback.

Conclusion 3: We welcome the steps already being taken by some local health boards and trusts to improve senior leadership involvement in complaints handling and urge them to build on this work as a matter of priority. Nevertheless, there was a clear consensus amongst all witnesses to our inquiry that, with regards to complaint handling, boards and chief executives need to provide leadership and take a more active and direct role. We believe that greater involvement of boards and chief executives in the handling of complaints is crucial to achieving the culture change called for by all our witnesses, and to ensure learning from complaints. We believe that chairs and boards must embed this as a priority and build the necessary infrastructure within their respective local health board or trust to deliver

[21] National Assembly for Wales, Health and Social Care Committee, *RoP [para 150]*, 16 July 2014

[22] Ibid, *RoP [paras 230-1]*, 16 July 2014

[23] Ibid, *RoP [para 24]*, 16 July 2014

[24] Ibid, *RoP [paras 204-6]*, 16 July 2014

improvements. This work should include consideration of the ways in which local health boards and trusts publish their information to ensure that it is sufficiently clear, accessible and understandable for them to be held to account.

3.2 Welsh Government

Mr Evans said he thought the profile of complaints management should be raised, and that while complaints management did not currently form one of the elements of the routine inspection regime, he would like to see local health boards and trusts reporting on complaints management to the Minister.[25] The RCN's oral evidence supported the suggestion that the handling of complaints should be considered alongside the clinical and financial targets on which boards are already held to account.[26] The Chair of Cardiff and Vale University Health Board said that she regularly discussed her approach to complaints handling with the Minister, but noted that there had not been an opportunity for local health board and trust chairs to collectively discuss implementing the recommendations of Mr Evans' report. She suggested that there could be merit in complaints handling being included as a tier 1 priority for local health boards and trusts,[27] a recommendation made in Mr Evans' report.[28]

Conclusion 4: In order to ensure that complaints handling receives the attention it deserves, we recommend that the Minister identify mechanisms – including the possible creation of a tier 1 priority in relation to complaints handling – to raise and maintain its status within local health boards and trusts, and to ensure local health boards' and trusts' performance is effectively measured and monitored. We believe that any target relating to complaints handling should not focus on the number of complaints alone; rather, it should seek to measure the quality of complaints handling, including how well complaints are processed, what lessons are learnt from them, and how this learning is embedded in future practice.

---

[25] National Assembly for Wales, Health and Social Care Committee, *RoP [para 69]*, 16 July 2014

[26] Ibid, *RoP [para 371]*, 16 July 2014

[27] Ibid, *RoP [para 214]*, 16 July 2014

[28] Keith Evans, *Using the gift of complaints: a review of concerns (complaints) handling in NHS Wales*, recommendation 56, June 2014

4. Sharing good practice and peer review

A clear theme emerging in our inquiry was the variation in local health boards' and trusts' performance in relation to complaints handling, and in their implementation of *Putting Things Right*.[29] This was attributed in large part to the varying levels and types of resource allocated by local health boards and trusts to its implementation.[30] Nevertheless, evidence provided to our inquiry suggested that there are many examples of good practice in relation to complaints handling and the identification and implementation of learning points, and local health board representatives told us that they are keen to adopt good practice where it is identified.[31] However, as Mr Evans told us, the structure of NHS Wales can be a barrier to the rapid sharing of good practice and innovation.[32]

Conclusion 5: We are pleased to hear local health boards and trusts are working to improve complaints handling, and that there are some mechanisms in place to facilitate sharing of good practice, such as the network of patient-experience leads. We believe that a focus on sharing good practice and peer review would assist in improving the consistency of complaints handling across NHS Wales, and that mechanisms need to be put in place by NHS Wales to aid learning by facilitating peer review.[33]

5. Staff dealing with concerns

5.1 Complaints handling teams

UNISON told us that complaints coordinators had raised concerns that they were under-resourced and, as a result, under "immense pressure".[34] This was echoed by Mr Evans, who said that complaints handling teams operated under pressure and had to deal with complex cases for bereaved and grieving individuals.[35] In his report he said that it was important that staff

---

[29] National Assembly for Wales, Health and Social Care Committee, *RoP [para 11]*, 16 July 2014

[30] Ibid, *RoP [para 11]*, 16 July 2014

[31] Ibid, *RoP [para 225]*, 16 July 2014

[32] Ibid, *RoP [para 17]*, 16 July 2014

[33] Ibid, *RoP [para 301]*, 16 July 2014

[34] Ibid, *RoP [para 316]*, 16 July 2014

[35] Ibid, *RoP [para 71]*, 16 July 2014

had the appropriate balance of skills and expertise, including clinician input, legal advice, call handling and communication, as well as the involvement of senior managers and leaders.[36]

Representatives from Abertawe Bro Morgannwg University Health Board told us that they were looking at resourcing to ensure that those within the complaints handling team had the correct skills and expertise, including access to clinical expertise, appropriate information, and customer care training. Work was also being done to ensure that staff from across the organisation felt empowered to raise concerns and to address feelings of mistrust.[37]

The Chair of Cardiff and Vale University Health Board indicated that she was attracted by the suggestion in Mr Evans' report that a national team could be developed to provide expert assistance with handling complaints, particularly the most serious in nature.[38]

5.2 Front line staff

UNISON and the Rt Hon Ann Clwyd MP noted that complaints may arise because of perceived poor customer service and poor communication skills.[39] The importance of all NHS Wales staff being able to communicate sensitively and effectively when faced with a potential complaint was emphasised in written and oral evidence.[40] Union representatives told us that they would like to see more use made of appraisal systems to highlight patient views and experiences to staff, and to support staff where improvements in customer service are required.[41]

Staff representatives also raised the issue of staff capacity and its impact on the number – and handling – of complaints.[42] The RCN's written evidence

---

[36] Keith Evans, *Using the gift of complaints: a review of concerns (complaints) handling in NHS Wales*, June 2014

[37] National Assembly for Wales, Health and Social Care Committee, *RoP [para 212]*, 16 July 2014

[38] Ibid, *RoP [para 206]*, 16 July 2014

[39] Ibid, *HSC(4)-19-14 Paper 6 Evidence from UNISON*/ *HSC(4)-19-14 Paper 2 Evidence from the Rt Hon Ann Clwyd MP*, 16 July 2014

[40] Ibid, *RoP [paras 71, 76 and 212]*, 16 July 2014

[41] Ibid, *RoP [para 342]*, 16 July 2014

[42] Ibid, *RoP [para 349]*, 16 July 2014

emphasised the importance of ensuring staff have sufficient time to develop a good relationship with patients and to respond to immediate concerns. A number of witnesses[43] emphasised the particular importance of the ward sister in this regard, noting that he or she could act as a "quality control mechanism" by speaking with relatives and patients to assess standards of care and identify any emerging trends relating to concerns.[44] The RCN argued that failure to allow this time for interaction with patients and relatives meant concerns could become complaints unnecessarily.[45]

Mike Jones, Chair of UNISON's Health Committee in Wales, warned against focusing on nursing staff alone:

> "…what we are missing is focusing on staffing levels for cleaners and porters. Often, when those numbers are short, those nurses are fulfilling portering duties… There are shortages in staffing levels in other areas, which takes nurses out of their main nursing role".[46]

Conclusion 6: Ensuring that an appropriate number of staff are available is crucial to the delivery of safe, high quality care. We acknowledge the important communication and handling role played by those on the front line, addressing any early concerns patients and their relatives may have.

Given that the *Putting Things Right* framework has rightly encouraged an increase in the number of people willing to report incidents and concerns, we believe that adequate resource, training and expertise must be put in place to deal with the volume of complaints. We recommend that the Minister give immediate consideration to the merits of Mr Evans' suggestion that a national team be developed to provide expert assistance to teams based within local health boards and trusts.

---

[43] National Assembly for Wales, Health and Social Care Committee, *HSC(4)-19-14 Paper 4 Evidence from the British Medical Association Cymru Wales*/*HSC(4)-19-14 Paper 5 Evidence from the Royal College of Nursing*/*HSC(4)-19-14 Paper 6 Evidence from UNISON*,16 July 2014

[44] Ibid, *RoP [para 349]*, 16 July 2014

[45] Ibid, *HSC(4)-19-14 Paper 5 Evidence from the Royal College of Nursing*, 16 July 2014

[46] Ibid, *RoP [para 354]*, 16 July 2014

6. Complaints about primary care

Mr Evans told us that in carrying out his review he had found that the current complaints regime did not sufficiently cover contracted GPs and dental practices.[47] Local health board representatives told us that they do monitor and address complaints in relation to GPs and other primary care providers, but that the complaints system in primary care needs to be looked at to ensure that it meets the needs of patients and the primary care system itself.[48] The British Medical Association Cymru Wales (BMA Cymru Wales) agreed with this, saying in its written evidence that *Putting Things Right* focused mainly on secondary care, and was "not sufficiently open to primary care professionals".[49]

Conclusion 7: We are concerned by the evidence we received suggesting that primary care is not currently adequately served by *Putting Things Right*. We note Mr Evans' recommendation that, as an all-Wales complaints system, *Putting Things Right* should be "strongly contained within local contracts".[50] We believe that greater clarity and understanding is needed about the applicability of the *Putting Things Right* arrangements to primary care services. We recommend that the Minister seeks clarification from local health boards about the steps they will take to ensure that *Putting Things Right* can be effectively implemented across **all** tiers of health care, and that it provides patients and staff with the necessary support to raise concerns that relate to primary care.

We requested a note from local health boards and trusts about the proportion of the total complaints received which relate to primary and secondary care. This information can be found on our webpage.[51]

---

[47] National Assembly for Wales, Health and Social Care Committee, *RoP [para 50]*, 16 July 2014

[48] Ibid, *RoP [para 294]*, 16 July 2014

[49] Ibid, *HSC(4)-19-14 Paper 4 Evidence from the British Medical Association Cymru Wales*, 16 July 2014

[50] Keith Evans, *Using the gift of complaints: a review of concerns (complaints) handling in NHS Wales*, recommendation 34, June 2014

[51] National Assembly for Wales, Health and Social Care Committee, *NHS C 06 – Additional information from the Welsh NHS Confederation*, July 2014

7. Recording informal complaints/incidents

The Rt Hon Ann Clwyd MP told us that many of the concerns that individuals had raised with her related to minor incidents which could easily be resolved at the bedside and need not escalate into formal complaints.[52] She agreed that it was important that these incidents should be captured in some way, and spoke about the benefit of providing pen and paper by each hospital bed, or displaying information about numbers of complaints on each ward.[53]

Mr Evans told us that recurrent small incidents could be indicative of systemic issues which need to be put right in order to avoid "catastrophic disasters", and that logging and effectively dealing with incidents or informal complaints could avoid escalation into formal complaints.[54] However, the BMA Cymru Wales thought that logging minor incidents which could be resolved at the bedside could be burdensome. It said that an alternative approach to identifying and understanding patterns of incidents would be to empower patients and all staff on a ward, clinical and non-clinical, to speak up about concerns, and enable supernumerary ward managers to take responsibility and provide leadership.[55] The RCN argued strongly in favour of applying root-cause analysis to incidents in order to explain why they have arisen.[56]

We heard from the RCN that previously use had been made of complaints and comments books, available on individual wards for staff, patients, relatives and carers to make comments.[57]

Conclusion 8: We believe that the recording of informal complaints or incidents is a key area in which progress should be made. We believe comment books would provide an informal way for both positive and negative comments to be made, and provide a qualitative record which would be available for review by board members and chief executives wanting to understand what is happening on the front line. We recommend

[52] National Assembly for Wales, Health and Social Care Committee, *RoP [para 124]*, 16 July 2014
[53] Ibid, *RoP [para 167]*, 16 July 2014
[54] Ibid, *RoP [para 76]*, 16 July 2014
[55] Ibid, *RoP [paras 344 and 346]*, 16 July 2014
[56] Ibid, *RoP [para 331]*, 16 July 2014
[57] Ibid, *RoP [para 349]*, 16 July 2014

that local health boards make comment books available across primary and secondary care settings at the earliest opportunity, and that health board chief executives and boards take account of the feedback provided by the books for performance monitoring and service development.

8. Support for staff

8.1 Fear of speaking out

Tina Donnelly of the RCN told us that in the last decade there has been a "sea change" in the way in which NHS Wales approaches and handles complaints.[58] However, we heard from witnesses and in written evidence that a blame culture still persists in NHS Wales, and that staff are still sometimes afraid to speak out about their concerns. In written evidence, the RCN said that nurses felt they were sometimes discouraged from raising concerns and completing incident reports,[59] and the Rt Hon Ann Clwyd MP told us that she had spoken to individuals who would not give their names, for fear of losing their jobs.[60]

Mr Evans told us that addressing this culture, so that staff feel able to speak openly, was "paramount to change",[61] but also explained that such change would take time and long term strategic planning.[62] We heard from local health board representatives that they recognised the need for cultural change, and that they were taking steps to lead that change,[63] such as Abertawe Bro Morgannwg University Health Board's 'See it, say it' campaign, which seeks to encourage staff, patients and relatives to report concerns or share good practice.[64]

8.2 Duty of candour

When asked whether consideration should be given to establishing a duty of candour within NHS Wales, the Rt Hon Ann Clwyd MP told us that it was

---

[58] National Assembly for Wales, Health and Social Care Committee, *RoP [para 309]*, 16 July 2014

[59] Ibid, *HSC(4)-19-14 Paper 5 Evidence from the Royal College of Nursing*, 16 July 2014

[60] Ibid, *RoP [para 152]*, 16 July 2014

[61] Ibid, *RoP [para 44]*, 16 July 2014

[62] Ibid, *RoP [para 83]*, 16 July 2014

[63] Ibid, *RoP [para 289]*, 16 July 2014

[64] Ibid, *RoP [para 220]*, 16 July 2014

important that honesty was encouraged, and that people should feel able to speak out if they have concerns that something is wrong.[65] Local health board representatives agreed with the principle of a duty of candour, saying that it was an approach that staff were encouraged to take.[66]

8.3 Feedback from complaints

Evidence to our inquiry suggested that, even when staff build the courage to raise a concern, sometimes it gets lost in the system or ignored.[67] Mike Jones of UNISON told us that, in many areas, staff are not given feedback which makes them question the value and purpose of reporting matters in the first place.[68] Carol Shillabeer, Deputy Chief Executive at Powys Teaching Health Board acknowledged that ensuring staff are treated well and made to feel that raising a concern is a worthwhile exercise that ends in positive action is a big issue.[69]

8.4 Whistleblowing

Ideally, staff and patients should feel able to raise concerns openly, and action will be taken to address issues. However, there will be circumstances in which it will be appropriate for whistleblowing procedures to be used. We were concerned to hear evidence that those who raise serious concerns through such mechanisms are worried about reprisal or victimisation, potentially even loss of their jobs. In its written evidence, the RCN said that its 2013 survey had found that 44% of its members would think twice about whistleblowing as a result of fear of reprisals, and only 34% would feel confident to blow the whistle.[70]

Conclusion 9: We are particularly concerned by the comments made about the fear of reprisal and victimisation that exists amongst staff should they speak out. We note that a duty of candour will be introduced within NHS

---

[65] National Assembly for Wales, Health and Social Care Committee, *RoP [para 128]*, 16 July 2014

[66] Ibid, *RoP [para 272]*, 16 July 2014

[67] Ibid, *RoP [para 327]* / *HSC(4)-19-14 Paper 4 Evidence from the British Medical Association Cymru Wales*, 16 July 2014

[68] Ibid, *RoP [para 357]*, 16 July 2014

[69] Ibid, *RoP [para 222]*, 16 July 2014

[70] Ibid, *HSC(4)-19-14 Paper 5 Evidence from the Royal College of Nursing*, 16 July 2014

England and recognise that this approach may have merit in promoting greater openness and transparency. Although we welcome the mechanisms put in place by the professional bodies and trade unions to assist staff confidentially, and the work underway in Abertawe Bro Morgannwg University Health Board on its 'See it, say it' campaign, we believe that more needs to be done to encourage an atmosphere of openness across NHS Wales. Furthermore we are concerned to learn that, even when staff muster the courage to speak out, feedback is not always forthcoming and reported incidents can get lost in the system. We recommend that the Minister require all local health boards and trusts to take immediate steps to ensure that all staff are encouraged and supported to raise concerns without fear of reprisal, and to ensure that staff concerns receive an adequate response.

9. Availability of complaints data

Mr Evans referred in his report to the lack of standardised reporting or comparable data in relation to complaints, and to the limited oversight or analysis of such information at an all-Wales level.[71] We note that the Minister has indicated previously that the Welsh Government was working with NHS organisations on a revised statistical return to aid standardised reporting.[72]

We discussed with local health board representatives and Mr Evans the possibility of making information about the numbers and categories of complaints available publicly, perhaps on the My Local Health Service website. There was general agreement that this could be a positive development. We are mindful, however, of the importance of ensuring that individuals cannot be identified through the reporting of information about their complaints, and that not everyone in Wales will wish to access information via the internet. We note the suggestion from Dr Chris Jones, Chair of Cwm Taf University Health Board, that, to provide context and aid understanding, information on the activity undertaken and the case mix that exists in different settings should be published along with the complaints data for those settings.[73] Similarly, we heed Carol Shillabeer's note of

[71] Keith Evans, *Using the gift of complaints: a review of concerns (complaints) handling in NHS Wales*, June 2014

[72] National Assembly for Wales, *WAQ65383*, Andrew RT Davies to Mark Drakeford (Minister for Health and Social Services), RoP p13, 5 September 2013

[73] Ibid, *RoP [para 235]*, 16 July 2014

caution that high numbers of reported incidents should not be viewed automatically as a sign of poor practice but as an indication that staff are willing to flag issues.[74]

Conclusion 10: We are concerned that there is a scarcity of publicly available data about complaints, which is frequently only available if Freedom of Information requests are made. We believe that mechanisms for proactively publishing information about the numbers and types of complaints received are needed. Such mechanisms must balance the provision of transparent, robust and accessible information with ensuring that individuals' personal data is respected and protected and that the context in which the data has been collected is explained clearly.

10. Response times

Responding to questions about missing the 30-day target for issuing a final response to a formal complaint, local health board representatives recognised that performance has not been good enough.[75] Nevertheless, witnesses emphasised the importance of the quality of the response as well at its timeliness.[76] Carol Shillabeer of Powys Teaching Health Board explained:

> "…you can do the quickest response and still miss the point, so if you have not satisfied the complainant of the issues, but you have delivered a letter in five days, that is not a good outcome".[77]

Local health board representatives stressed the importance – for both the complainant and the complaint handler – of face-to-face contact when dealing with a complaint, as opposed to paper contact alone.[78] We were also told that the complexity of some complaints renders their handling far more difficult and lengthy than more straightforward cases.[79] Local health board representatives agreed with the suggestion in Mr Evans' report that it would

---

[74] National Assembly for Wales, Health and Social Care Committee, *RoP [para 224]*, 16 July 2014

[75] Ibid, *RoP [para 247]*, 16 July 2014

[76] Ibid, *RoP [para 248]*, 16 July 2014

[77] Ibid

[78] Ibid, *RoP [para 251]*, 16 July 2014

[79] Ibid, *RoP [paras 249 and 251]*, 16 July 2014

be sensible to consider breaking down the component parts of the response timescales to better support the achievement of responses with the 30-day target.[80]

Written and oral evidence emphasised the importance of ensuring that communication is maintained with complainants throughout the complaints process. Mr Evans' report noted that:

> "there is a general feeling of a reactive rather than proactive approach to communication, with a lot of onus placed on the complainant to track progress".[81]

Carol Shillabeer of Powys Teaching Health Board explained that the approach in her area includes making immediate contact with a complainant to note that the complaint has been received and is being dealt with, and that he or she will be kept informed of progress.[82]

Conclusion 11: We believe that significant improvement is needed in relation to providing responses to complaints within the specified timescales. We acknowledge the importance of high quality as well as timely responses and note that complex cases may require a longer period of consideration. Nevertheless, we agree with Mr Evans' recommendation that timescales be broken down into component parts to better support the achievement of responses within the 30-day target (and increasingly well within) and we recommend that the Minister accept and pursue this. Furthermore, we recommend that local health boards ensure that mechanisms are put in place – similar to those described in Powys Teaching Health Board – to improve communication with complainants during the period in which a complaint is being processed to ensure that they are kept abreast of developments.

---

[80] National Assembly for Wales, Health and Social Care Committee, *RoP [para 253]*, 16 July 2014

[81] Keith Evans, *Using the gift of complaints: a review of concerns (complaints) handling in NHS Wales*, June 2014

[82] National Assembly for Wales, Health and Social Care Committee, *RoP [para 249]*, 16 July 2014