

A REVIEW OF CONCERNS (COMPLAINTS)
HANDLING IN NHS WALES

“Using the Gift of Complaints”

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“Using the gift of complaints”

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CHAPTER 1: TERMS OF REFERENCE

1. The Minister announced the establishment of a 12 week review into the way NHS Wales handles concerns and complaints. The Review of Concerns (Complaints) Handling in NHS Wales has been led by Keith Evans, the former Chief Executive and Managing Director of Panasonic UK and Ireland, supported by Dr Andrew Goodall, Chief Executive of Aneurin Bevan University Health Board.

Terms of reference

2. In summary, terms of reference for the review include:
 - **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 within the process;**
 - **Identify how the NHS in Wales can learn from other service industries; Consider the wider cultural ‘patient’ service ethos and how staff are supported to deal with patient feedback;**
 - **Identify how the NHS can demonstrate it is learning from patient feedback.**
3. In introducing the Review, the Minister said:

“The vast majority of people tell us they are happy with the care provided by the health service in Wales, 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.”

“The current system for handling concerns, based on the principle of ‘investigate once, investigate well’ is almost three years old. It is therefore timely that we review how well the NHS in Wales handles concerns and build on the progress already made.”

“I am keen that we learn from those with a track record in excellent customer care in other sectors. I have therefore asked Keith Evans to lead this review, which will begin immediately and report back to me after three months of investigation.””

4. The review should produce a report making practical recommendations for improvements in these areas in both the short and longer term.

CHAPTER 2: PERSONAL INTRODUCTION AND REFLECTIONS

5. I feel very privileged to have been asked to undertake a review into complaints into an NHS that touches all of us in the care and treatment it provides to families and communities across Wales. I have approached this seriously, acknowledging the commitment of many staff and organisations to deliver good NHS services at what are difficult times for public services, but also with a wish to comment honestly and to offer observations and recommendations for improvement. I acknowledge the many positive experiences and indeed high satisfaction ratings from patients accessing these services across all areas of Wales. However, any review that is focusing on complaints and concerns is inevitably going to be exposed to difficult issues, personal stories and commentary about organisational and professional responsiveness. So whilst acknowledging the positive in the context of many examples of good service and patient experience on a daily basis right across the NHS – from GPs to specialist hospital services, I am focused on my role which is to respond to the Minister’s request for clarity and improvement.
6. I would just like to lay out some of my credentials at the outset of this report, informed by my career experience, my specific experience of 33 years in the Panasonic Corporation culminating in my role as Chief Executive and Managing Director for Panasonic United Kingdom and the Republic of Ireland. This latter position included my role as a senior executive in the Panasonic European organisation and as a Global Corporate Executive of the Panasonic Corporation.
7. My expertise covers most aspects of industry management and business leadership, from initial research and development through to customer services. In particular, I have over many years of experience personally learned the importance of customer care and of the great benefits that this can bring to any organisation, as well as understanding the calamity of what can ensue if these basic areas of courtesy and attention are not adhered to. I am in this respect a firm believer in developing people first and, in so doing, providing the correct work ethos that will foster pride in delivering all that is best for those who do you the honour of either purchasing your products or using your services. Furthermore I believe, whatever your job is, wherever you work and whatever you provide it is extremely important that you humbly wear your customer’s shoes and place yourself in their position at all times. If you do it will quickly bring you to the daily issues of what is going right and wrong. From a customer service perspective, it is important to accept graciously the kind assistance of those who have been so far patient with your shortfalls and to let them teach you how to put them right. It is this part of my skill set that has been predominantly engaged in this review of Putting Things Right.
8. Given the size and operation of the NHS in Wales I am minded of a comment made to me during the course of the review that even the highest satisfaction

ratings, which are to be acknowledged and celebrated, can still leave thousands of patients and users dissatisfied with the care they have received or the way they have been responded to within a complaints process. As I have indicated, the nature of the Review means it has been necessary for me to listen, reflect and comment on these more negative experiences in order to drive the improvement I see is genuinely possible, most within the gift of the NHS, and to set these out as clear recommendations for action. Although I am reflecting what I have heard alongside my personal insight into good customer care and organisational leadership, I am indebted to those who have been prepared to speak to me openly and honestly through the course of the review, in particular the strong patient views shared with me. All involved have shown a wish to be better, to provide clarity, to be more responsive and to show that lessons have been learnt from any poor experience. 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.

9. My own specific experience of the NHS is like any other member of the community; that is at times as a patient, through the experiences of family members, and of course during times of joy and sadness given the breadth of services provided to us free at the point of contact by the NHS. I have also had family members who have worked for the NHS and seen at first hand the commitment and dedication of NHS staff. I will comment immediately that my own and family experiences have been in the main positive; but that in saying this I do see the potential to do more and better on behalf of other patients and families across Wales. I am sure this is also the wish of the over 70,000 staff who work on our behalf in the NHS in Wales, who similarly don't just provide services, but will also be recipients of the NHS through their own personal and family situations and living in our communities.
10. I, like others, am very proud to live in a country where an NHS that we know and admire is available, offering care to all free at the point of treatment, and is a recognised institution across the United Kingdom. We have as a strong foundation a context that everyone wishes the NHS to be able to support and deliver for us in our respective times of personal crisis and illness; but we should also be allowed to promote our ambition for this to be a leading service, keeping ahead of the pressures, changes and demands placed upon it. I have tried to bring this ambition to the reflections and recommendations of this review, as no one I have spoken to, from either a patient or service perspective, has objected to a need to further improve and refine the complaints process as it stands. In many respects, many of those I have spoken to know what needs to happen and have

clarity on actions to make improvements; my role has been to capture and develop these and bring them together as a collective set of recommendations and a challenge to take the opportunity to change.

11. Nevertheless, the Minister has acknowledged in requesting this Review that there are aspects of Putting Things Right and the complaints process in place in Wales that are not working effectively as he would wish and I welcome the openness of the Review he instigated by asking me to lead this, perhaps unusually, as a non-NHS commentator. I accept that my experience means that the lens I use for this review may be different, but I hope this will allow innovation and improvement to emerge with an urgency that respects the responsibilities to be discharged to patients and families passing through this vast array of service from primary care and GPs to hospital services, from dentists to community based services and from local centres of excellence to highly specialist services.

Putting Things Right

12. There is little that industry can teach the NHS with regard to the delivery of front line expert medical or clinical services. The NHS continues to be regarded by many as a world leader in the field of mass advanced healthcare delivery.
13. It could be said however that the NHS can feel trapped by its own culture, struggling to modernise itself from a model of care still built around its inception in 1948 and failing to accept change rapidly enough for its coming future requirements as would industry and business. It doesn't look beyond its own boundaries enough to develop innovative ideas even when it is delivering on a range of priorities. It is not driven to change for the better by the commercial influences such as strong competitors in the same field. Should this matter? In my view, yes! With no alternative options and the current outlook for the aging society the NHS is in a position that many business organisations would be deeply envious of – an endless supply of long term customers that can go nowhere else! Competitive betterment however is starting to emerge as with the advent of devolved health to regional government we can start to see comparisons being made that inform us of the levels of performance of the NHS in Wales compared to other regions. Is it better or worse than the other regions? Is it performing as well as it should be in specific fields and areas? There are other mechanisms for determining this, but in the context of specifically seeking to improve complaints management and other areas I would say that once agreement can be made for proper UK benchmarking on all subjects, regional health bodies will want to not only be equal but also to be the better of the other regions in all aspects of their activities. From this premise NHS Wales has a chance to positively demonstrate its own performance and in doing so to give confidence about adopting an open environment to improvement and better ways of working, including better management of and learning from complaints.

14. The NHS should also learn how to capitalise from better engagement from those whom it employs and in particular those who use its services, as does industry on a routine basis. By nature of the services they offer and the environment they operate within, industry and business is by far better at placing the customer first and at the centre of its attention; this means listening to and analysing what they are saying and requesting and getting change in place to reflect the customers' views into their organisations offerings.
15. All organisations - big or small - must develop a culture of honesty and openness if they wish to be able to learn from their mistakes and improve their activities in a manner that will engage a process of continual excellence for those who avail themselves of the services on offer. Using the information gathered from users is a vital analytical tool in ensuring that the organisation is not arrogantly pursuing its own cause and direction when it is not bringing satisfaction to its benefactors. In this respect the NHS in Wales has established the Putting Things Right scheme as a positive sign that it should accept responsibility for its mistakes and show compassion for those who have been mistreated and ensure that they will receive redress in what should be a fair and amicable way. As taxpayers and as users of its services we should applaud the stance and spirit of Putting Things Right as a core strategic philosophy of the NHS as it means that the NHS is seeking to take responsibility for its actions and outcomes.

How has Putting Things Right been implemented?

16. At inception the Putting Things Right concept was hailed by all as a step in the right direction to help put an end to lengthy litigation processes and overdue complaint handling by investigating once, with quality, preventing repeat issues and learning and applying improvement. Has this been achieved? From feedback, only to a certain extent. However, the intentions of Putting Things Right remain well regarded.
17. The introduction of Putting Things Right in 2011 closely followed a major strategic reorganisation of NHS structure across Wales which had led back in October 2009 to the formation of the current seven Health Boards and three Trusts. During this period and as remains the case today, in my view and despite good intention, adequate resource has not been made available to allow the effective management of PTR on a local and national level. Currently, I would reflect that there are potentially at least ten different versions in play as Trusts and Health Boards have taken it upon themselves to implement PTR in their own way according to their budgetary means, respecting the individual accountability of each organisation. At a time of austerity and tight budgetary management this has meant that complainants have potentially struggled within the process as Putting Things Right has positively been successful in generating the ability to complain and therefore receive higher numbers of complaints, but not necessarily had the complementary infrastructure to keep pace with this.

18. In an analysis of approximately three hundred pieces of correspondence requested and received within the Review process, the number of complainants actually feeling dissatisfied with their experience of the PTR process or the care they have received is quite disturbing to see. I acknowledge that the NHS asked people to get in contact with it to reflect on their experiences, and this is therefore more likely to be in a negative context. Nevertheless, this provides a justification for the Minister's request to seek improvement and innovation building on the PTR guidance. At the same time, we have come across other measures that show that complainants have at least through the PTR process felt that their complaint was responded to and did not need to pursue it further.
19. Through analysis and during the course of visiting the different organisations across Wales it is also quite common to discuss repetitive incidents, same subject incidents and untimely complaint handling. This means that better practice, which should be picked up from the process, may not be or is not being applied to the workplace quickly and efficiently enough. Certainly, it seems that learning is not being applied as broadly as it could be above the individual complaint; and this becomes particularly difficult when assessing whether NHS organisations themselves share their learning across the structures in NHS Wales as a matter of routine.
20. Most complainants have had to overcome an enormous organisation to make their complaint in the first place, often feeling a lack of support and isolated during the process. Some have spent years just simply trying to navigate the systems, find for themselves the way through procedures and organisations, building up in some cases boxfuls and roomfuls of correspondence. The saddest point of all of this is that even though they may be aggrieved about their treatment or suffering bereavement, in the main they are fully justified in their aim that they are simply trying to prevent the same happening to others. In many instances a defensive stance has been taken with these users of the NHS and yet these are the exact people that should be constructively engaged with, in a humble manner, so that their experiences good or bad can be reflected into their health service. Its leaders and employees need to ensure that a listening and compassionate NHS is in place, reinforced by a clear and responsive concerns and complaints process and in line with the vision set by its founders.

The complaint, incident and concern - accepting the gift.

21. An organisation of any sort – public or private - that cannot receive a complaint with heartfelt thanks and deep appreciation will never succeed in the long term. It is in its own way a clear and singular message from those who use its services and the most direct way in which they can express their opinion about anything that has been provided to them. It should be taken seriously by the provider and treated with care and attention until the issue it is highlighting has been fully resolved.

22. In my own experience I have always treated a complaint as a “gift” and taught and trained those I have led or managed to do the same. If another person has used your services or purchased your products they have taken a basic stance of trusting you and in using your services or products has taken a step to enhance their own life and enjoyment. It must always be kept in mind that when this process takes place, users of services and products make a commitment to the organisation of trust not only in its products or services but in its people as well.
23. It is important to consider what comes in a complaint that successful organisations respect so much. It is simple - it's information! It does however lead the way to improvement, innovation and betterment for users if there is readiness to accept the complaint openly as a gift. Many organisations can spend large amounts of money on user surveys when in practice the answers that they are looking for are under their noses in the complaints files. I would argue that it is therefore a better solution to invest time in and align resources to the complaints system and to manage it effectively, as it will provide key indicators as to what to remove or improve. Developing the ability to assess the contents of large numbers of complaints quickly will pull issues of concern to the front line with speed and allow you to analyse your users' needs deeply, allow your teams to react more sympathetically and with greater speed and efficiency. Most importantly, it will prevent repeated bad practice that will soon result in malfunction within the organisation if not stopped.
24. Commercial organisations that ignore complaints will eventually disappear unless they are unique in as much as they have no competition or provide services that are the only option available. In these cases of single provision, which fits with the environment for the NHS, it is even more important that there is a fully controlled complaints system in place as the level of trust put upon these types of organisations shoulders by its users is total.

Being open about receiving complaints

25. Once an organisation has decided to be open and honest with itself about its status in the eyes of its users, then it should consider how to allow its users to know that and show them how they can offer their complaints and concerns anywhere and at anytime. In these exciting days of technological change, exceeding any previous decade in terms of speed and application of innovation, the receiving process has to cover a variety of apparatus from basic pen and paper or verbal conversation through to the latest technology devices and their high speed forums such as Facebook and Twitter.
26. The complaints mechanism, in this case Putting Things Right, should be visible as a brand and easy to access at all times, anywhere and especially through the people in the organisation who should be well trained in its methodology and their readiness to help with the use of it if required. This link to effective

communications again has implications for the traditional NHS perception of complaints infrastructure.

Keep it simple, standard, slim and speedy with excellent quality

27. Anyone wishing to make a complaint wants the process to be as simple as possible for themselves or their personal circumstances. There is nothing more frustrating than trying to navigate a complex complaints system or even a simple one if you physically cannot manage it. It is frustrating and aggravating and often worse at a time when the user is at low ebb because they feel badly let down by the services or products you have provided and you have broken the basic rule of trust. The system should be standardised in every way and everywhere; there is nothing worse than having a confused complaints process throughout the different divisions and departments of a large organisation. Users often complain more than once before they reach the top level of an organisation, so I would advocate not confusing matters further by complicating the procedure. Based on my business experience, my advice is to keep the complaints system slim and singular and ensure it has all of its required skill set in the team to ensure that a complaint can be managed effectively and efficiently. It is often thought that big organisations have to be complex but, in my experience, a well managed and understanding user interface with trained and professional teams will give users a seamless “end to end” view of the organisation.

28. Many organisations develop rules and regulations that in the end simply serve to shade them from the reality of the user’s poor experiences. Speed in resolving the users issues is paramount it is the basic duty of the providing organisation to resolve issues quickly and sort them out in as amicable manner as possible whilst deeply considering the seriousness of the circumstances. This also means responding to the specific handling of concerns, such as in respect of older people, children, or patients with debilitating health conditions.

Wearing the users’ shoes!

29. At all times, all team members from top to bottom and wherever they are in an organisation dealing with users should constantly think of themselves in the user’s shoes! In a customer-facing organisation where the customer is first, this is always the case. Having and maintaining this attitude will always reduce the complaint levels at source and turn them into a concern or incident that should be reported by team members for innovative analysis. In the example of the NHS, wearing the patient’s notional shoes should bring a more humble disposition from its team member’s as you would not wish to be in the same undesirable circumstances yourself. Organisations that do not train their executives and staff in this principle are in the main seen to be non-listening, but can also be perceived to be egotistical and arrogant even if this is not intended.

Creating the right atmosphere

30. 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. This practice can only start in the Chief Executive's office. The leadership of the Chief Executive and consequently the Board to the operational teams will in the end define the manner in which your customers are treated. For example, arrogance, contempt, rudeness and bullying will be experienced by your users if this is what is applied to staff members on a daily basis from the top! Conversely, honesty, cooperation, leadership and humility will also be reflected if they are the leadership stance and will be deeply appreciated by the users and those who wish to complain or voice an opinion. The environment for NHS Wales should easily allow for the latter experience – but it was clear in talking to patients and complainants that organisations and those at the top were often seen as “they” or “them” rather than the people committed to the NHS that I know they are with clear commitment and values to good services, quality and positive patient outcomes. There is much work to do to create a different relationship for the future in the complaints arena and my role in refreshing Putting Things Right I hope will allow and reinforce this.

Categorising Complaints

31. All complaints should be recorded and categorised and staff should be encouraged to report all verbal complaints into the system as soon as possible even if they have been resolved at source. I know this will typically be seen as creating additional burden but it is necessary to be able to use the complaint data to analyse trends or low level repetitive issues early and before they become a major event or systemic failure. It is the constant monitoring of all levels of concerns and complaints that will drive specific change in processes of management that will keep users content. Corporations pursue customer feedback all the time through their questionnaires but better corporations will also actively pursue this through general discussion. Asking questions and listening to the answers is one of the most effective ways of monitoring customer satisfaction and is a skill set that should be trained into the organisation so that it becomes automatic. Conversely, analysis of compliments can also provide quick reflection in activities that bring satisfaction. Merging these two data levels is important and it also provides good balance. However, compliments should not be seen as a means to ignore complaints and concerns information. Correct and proper analysis should be used for all.

32. Once this mechanism is in place, and it has been decided at what level complaints should be escalated, more senior staff should be involved. Lower level complaints can be analysed quickly and routinely (even by simple spread sheet) on a weekly basis and should be reviewed as a matter of routine by the

Chief Executive and his executive team on a weekly basis. The personal management of more serious complaints should be allocated to senior General Managers, senior clinicians in the management structures or Directors who should be available to work closely with the complainant and/or their carer's and relatives until the issue is resolved.

33. In my own view, it does not feel right that within the complaints process sometimes the most junior members of the team, without appropriate or full experience, are being left to manage the most serious complaints or issues on behalf of senior executives and clinicians. I really see that Executive champions are needed to be in place with the most serious complaints and that senior individuals should be seen to be available to users.
34. A comment I would also make is that there is a danger that the Putting Things Right scheme throws every potential complaint, ranging from enquiry through to legal case, into the same category for responsiveness. The setting of responsiveness targets, currently set as a maximum 30 day target, per se is a good thing – the danger is that all complaints get dealt with consistently to this maximum target when I have observed that some should simply be quickly and professionally responded to well within such set times. Conversely, significant legal cases are never going to be processed within such shorter complaints timescales and this is where getting the balance right of redress or future legal action becomes important. It is very important to involve the complainant especially if longer time scales are needed to investigate and resolve the issue. Targets are a good thing to calibrate the process, but can become a distraction from a good, professional response often framed by common sense.

Becoming Patient Focussed

35. Although clearly operating in a patient care environment, I would argue that in the complaints arena the NHS is currently not a patient-focussed organisation; rather it is a systems-focussed organisation. The management of most areas in the NHS is based around systems that have been set up in the main to manage the expectations of the respective Governments' view of healthcare.
36. To put the patient truly at the core of the NHS direction is an undertaking requiring an enormous mindset shift so that every single patient can be treated uniquely. Despite high volumes of activity, the environment needs to give every patient an individual experience with care and compassion. The NHS is there for its patients who should be supported by its professionals, but it is not for the professionals. I have heard the latter comment through this Review. Board room to ward and back again; everyone should have the patient as the priority focus.
37. Corporate companies are usually strongly focussed on the customer's requirements. They know that putting the customer at the core of the organisation's strategy in all aspects of the development of their product,

customer care and service portfolio is what will generate their success in very competitive fields. Putting this type of customer first mind set into the NHS is both necessary and a long time overdue.

38. The customer journey in the corporate world is constantly studied and analysed. Technology has made this type of research more immediate but in the past systematic management of customers details in paper data files also provided the relevant analysis and subsequent attachment to the customer's journey to purchasing your goods and services. Looking after your customer and meeting them along the journey on a regular basis through information technology and social media is now critical. For example Twitter and Facebook are considered very important and is a major task for most marketing and PR departments. However, in the business world the matter cannot stop with just a purchase; the demands from the customers require a range of after sales activities to ensure satisfaction has been achieved. Speedy and prompt delivery, arriving with the correct devices or tools, effortless installation, removal of unwanted packaging for you, at or online home training, customer feedback meetings, questionnaires etc., and a spirit to be always asking, always listening and always innovating. These activities have to be carefully organised and managed and cover many different departments and organisations.
39. In a similar way all of the various aspects of social services, primary and secondary care, the ambulance service, Community Health Councils all need to be organised to provide a seamless experience. Keeping the competitive edge, through end to end management of your customer base is essential and second nature to business. It needs to be continually re-evaluated in healthcare not only to provide better service but also to prevent inefficient money management and financial waste. Just stumbling along as you were doing before will not provide the focus that your customer demands from the organisation day in day out. If you cannot get a grip on this mentality then your customers will leave you and go elsewhere to seek satisfaction. I am encouraging the NHS to adopt this type of context and constant attention to your customer ... the patient, as they have little option to go elsewhere.

A confused space for patients

40. One issue that has been clear to me in coming to this Review and the NHS with fresh eyes is that the navigation through the complaints system – and which point to access when – and when a complaint reverts to a legal process – and when independent investigation acts to support – is not easy for either the users or indeed staff to describe. I hope that in this Review I can at least help with some clarity of how I see the current system operating and the different levels of access and support as well as refine these through some supportive recommendations. I was really struck to hear in an evening session set up to share patients' views how many were unaware of the Community Health Councils in Wales and the

specific independent complaints advocacy service they lead. In fact many were unaware of the broader role that Community Health Councils play. There may be a need to clarify their role and make them more visible even within the hospital or service space. Communicating the system and its structures is, for me, as important as commenting on the improvements to the system.

41. I would comment that I am surprised that NHS Wales does not take more advantage of its national focus and identity as NHS Wales to create consistent infrastructure and expertise on a more national basis. In my experience, any commercial organisation would alongside maintaining local structures for delivery of services be bringing together critical mass wherever possible; there seems to be significant potential to create a better working and collaborative arrangement across Health Boards and Trusts in NHS Wales, particularly if the outcome is better and it delivers a more expert response to patients and complainants in a timely way. If the current more local system has weakness in delivering the infrastructure and responsiveness for complaints, a more national platform to bring together the expertise, infrastructure and learning would be a sensible option to pursue. There is more variation than I would have expected, probably as a result of the individual accountability of the different organisations, and despite a consistent and standardised set of expectations facilitated nationally through Putting Things Right. Some variation is positively showing responsiveness, leadership and innovation; however, some of the variation is representing poor local response and areas for improvement. If the best characteristics of organisation across NHS Wales were taken, I have no doubt there would be a better and more responsive complaints structure in place.

The impact of NHS environment

42. I have been genuinely concerned by the environment within which the NHS in Wales is working. I am mindful that my comments here will apply to the NHS more generally given the history and structures that are in place. My comments are generated by the flexibility with which I have been able to lead and manage my organisations and responsibilities in the commercial sector and in the global field. However, they also focus on the way in which a negative environment can be created very quickly around the NHS; in my experience, a constant barrage of negativity can easily become the norm for those working in services. There is a leadership responsibility to step back from this and to lead the way for positive response and innovation, as well as clear response to problems that may have been highlighted.

43. Clearly the NHS cannot avoid operating in a political climate. However, leadership and management can be directly affected by the level of political debate across parties that ensues and my own observation would be this is directly affecting staff morale. This can lead to over-specific requirements and a micro-management of individual issues from government that can stifle the

leadership and innovation that is necessary to be a responsive, customer-care driven organisation.

44. I have observed how the political debate and general blame culture is too heavy and seriously affects those working in the service. In this respect I am not just focusing what this means for the leadership of the organisation; I am commenting that the many staff I have come into contact with right through and across structures in NHS Wales are genuinely struggling with constant negative publicity. There is a danger that if not recognised, this will simply create deeper trenches at the sacrifice of honesty and openness. My review has drawn out many reflections and recommendations in respect of the importance of creating an open and honest culture. Those operating and commenting outside of the day-to-day NHS, even when quite properly discharging oversight necessary for our public services, have a similar responsibility to create this environment. The development of a no blame environment is about the creation of a culture for change for the better.

45. This was reinforced as a general reflection within the recent “Trusted to Care” review:

“There is also no question that where issues of serious concern are raised there should be appropriate mechanisms for investigation and resolution. However the collective responsibility of those inside the system, those charged with regulation and the public should be not to catch out and blame, but to identify, correct, prevent and resolve issues constructively, so that the way hospitals work and services are provided improves.”

46. The level of focus and commentary is the most I have ever seen and experienced. For particular reasons, business simply does not have to operate with these constant commentaries, particularly when everyone I have met is looking for positive change and progress. It is not found in other areas of employment in such vast quantity. Openness and honesty will never be forthcoming in organisations that foster blame and criticism as the tools of management. As a result the siege mentality I have observed is the highest I have ever come across. In a busy environment, with high professional and public expectations, I can see that this is taking the energy of members of staff at all levels. I have seen and heard deep reflection from staff as to the environment they are experiencing and not all of this is of the making of Health Boards and Trusts. There are indicators that show the impact this could be having such as difficulties in recruitment, higher staff turnover, higher numbers of complaints, staff reporting concerns outside the organisation and impact on quality outcomes. It also has in some instances caused anxiety for patients who are using or expecting to use services.

47. I have seen a genuine and positive response across NHS Wales to the seriousness of the Francis Inquiry and what took place in Mid-Staffordshire. There has been an impact of this, not least a deep professional reflection on how those circumstances could have been allowed to happen in the first place. NHS Wales has set out its formal response to the Francis Inquiry at the Welsh level, but I recognise it has hit organisations to the core. What I am unsure of is whether it has actually made people more frightened or more open in the PTR processes.
48. I have asked questions at all levels about the ambience in the workplace during before and following the Staffordshire Incidence and the Francis Report. Most people especially nurses have said that it is easier to speak the truth and act with candor than before. In fact they have all said that the incident has made them question themselves deeply as to the moral issues that have been raised and to be even more ready to speak out against the conditions that caused the incident and similar happenings in other hospitals. This is good for the NHS and should be built upon as it is good for any organisation to be compelled to do the right thing. Members of staff have commented that it now generally feels moderately easier to complain but this is an issue of confidence; it feels easier to handle and receive a complaint; and it is from a mindset perspective easier to report incidents and concerns. This is almost a moral reinforcement of what the NHS should be about to all of us, whilst putting excellence in care and treatment as core business and with due regard and attention. Sadly some of the cultures now wrapping themselves around the NHS, through observation and comment, are not providing this.
49. It must be very demoralising for those who work hard and professionally after a long day's work to go home and be blamed on the news and in the media, although I fully accept and highly regard the important role the media play in investigating and informing the public. Difficult media coverage is a symptom of where the NHS is; however it is the NHS's responsibility to improve the system and services it oversees in order to achieve more positive commentary. As I have said I have never experienced the same in my career in other fields on such a constant level. It is in fact wearing the NHS employees down and exhausting those that we expect to look after us when we are at our lowest ebb. Blame also has an ability to flow downhill and so in many cases it is those furthest away from the commentary that carry the weight of it on their shoulders. Yet they carry on, as unsung heroes do and amongst it all give of their very best to care for us when we desperately need it.
50. Organisations that allow blame culture to persist will never be open in their culture and you can normally assess this by the number of covered whistle blowing provisions found in the organisations. It is therefore in the better interests of the NHS customers, the patients, that those overseeing NHS services step back and take a very close look at the true cost of blame culture and the effect it

is having on the organisations mindset and the manner in which it is preventing honesty and compassion where it is most needed in the one metre of space that surrounds a hospital bed.

The NHS compared with industry

51. I have some reflections on the way the NHS management structures discharge their business as a contrast to my experience of industry. In saying this I accept that the NHS is a large and complex organisation, operating a range of different services in different environments. However I would argue that in practice there are too many levels of horizontal and vertical management; it is probably the most complex matrix organisation I have ever come across and mostly of its own making. In my view this really affects the PTR concept as it has turned clear and well-intended guidance into a slow process across the massive structure. Moving a complaint and gathering information suffers as the boundaries of sections and departments struggle to communicate effectively.
52. Processes are slow and cumbersome with hundreds of touch points that in turn become weaknesses where control can be lost. Responsibility and accountability are usually separated so member of staff are not confident to accept empowerment. In turn this causes lock down in the culture and the NHS is then trapped by its own culture and falls silent. All of those thousands of people who could powerfully change the NHS, its own skill set and experience are locked down by its organisational culture.
53. Matrix communication chains are too long and in the end are not effective at communication. As far as complaints are concerned, there needs to be some simplification in management systems and a real focus on creating the skills at the frontline. This also requires clinical staff to have confidence that they can act and respond on such concerns as they emerge, but also to have confidence that they can raise their own concerns where there is an impact of quality and safety or patient experience. None of this abrogates clinical staff from their own responsibility to be part of positive change when this is targeted at improving the patient experience, and specifically where it is responding to patients' own reflections.

CHAPTER 3: EXECUTIVE SUMMARY

54. I have intended to undertake a comprehensive review of the current system and improvements that can be taken forward. This has meant listening to patients, users, stakeholders and staff, and in an informed manner setting out my own view of changes that can be practically taken forward. There are therefore deliberately a comprehensive and wide-ranging set of recommendations, intended to give practical support to improve process and culture.

55. However, some of the key areas that I would highlight as important to ensure are taken forward are the following:

- Make the existing Putting Things Right scheme clearer and more visible; I have heard few criticisms of the concept of the PTR scheme, but its implementation has led to unnecessary variation. This means raising awareness nationally but also ensuring this is addressed locally within organisations and visible across sites and services.
- Address the lack of infrastructure to accommodate the current levels of concerns and complaints that have positively increased through the intention of the Putting Things Right process when launched in 2011. I have seen very committed staff attempting to maintain responses in the face of growing demand; however, I do not think the resources have yet been aligned to allow this to be undertaken in a personal, compassionate and comprehensive way.
- Approach contact and correspondence in a personal way, acknowledging the individual experience that has occurred and do everything possible, including accessing independent advice, to ensure the complaint itself is undertaken in a professional manner and with active communication at each stage.
- Increase the profile of the analysis of incidents, concerns and complaints, both themes and current performance, at the Board level; this means acknowledging the importance of this subject matter as a rich source of patient experience that can lead to improved services and ensure that actions are implemented with impact so that prevention of repeated poor performance is undertaken.
- I have struggled myself to always make sense of the different and sometimes it seems conflicting roles within the complaints infrastructure. Imagine how this must feel for individual complainants without the access to the system I have had. There is an opportunity to better clarify respective roles in support of complaints across existing organisations, patient groups and regulators. If the existing system is unable to better navigate complainants through the

system, including the option to quickly resolve locally, I have advocated the role of a national complaints regulator within the PTR scheme as a recommendation for serious review.

- Establish nationally, but with consistent local implementation, customer care training programmes appropriate to the NHS, that can have a large scale impact on the way complaints and individual concerns are handled right across the services in Wales. This means learning from other examples of programmes that have focused on values and achieved good penetration at local levels, such as the 1000 lives scheme. As I advocate in my report this approach to care as the way things are done needs to genuinely focus on the 1 metre zone around the patient and their individual experience.
- Improve the availability and consistency of information available nationally, in terms of complaints numbers, responsiveness and themes for analysis but through the consistent and correct use of the existing complaints database DATIX.
- 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.
- Despite all temptations to do otherwise in the face of a difficult and very public environment, ensure that a no blame culture is developed and maintained at all levels. This is the key to success, as is represented by those public service and commercial organisations that are leading in their approach to learning, innovation and performance. This will allow a proper commitment to openness and transparency to be discharged.
- Ensure through the organisation that through effective training all those who represent the NHS are developed properly for their role and can operate to the correct levels of professionalism whatever their job. By doing this, and through correct staffing levels throughout, empowerment, responsibility and accountability will become reality in the workplace and contribute to a better and more compassionate NHS receiving less complaints.
- Develop the concept of Board and executive complaints champions and further strengthen this with suitable advocacy and support services.

56. As I have indicated, each individual complaint is a gift to be used proactively to achieve better services and improved quality of care. During the course of my review I have seen much commitment for change to happen and for real improvement. I hope that the NHS in Wales, its stakeholders, its users and its staff will allow this to be achieved.

CHAPTER 4: CONTEXT AND BACKGROUND

57. The NHS in Wales has always had complaints systems in place in order to resolve concerns and incidents, with Putting Things Right representing the latest guidance in place.

Development of Putting Things Right

58. In April 2011, the Welsh Government introduced new arrangements for the management of concerns: *Putting Things Right*. These arrangements were underpinned by a comprehensive set of regulations and supporting guidance. They introduced a single more integrated approach bringing together the management of complaints, incidents and claims, based on the principle of ‘investigate once, investigate well’. It aimed to make it easier for patients and carers to raise concerns; to be engaged and supported during the process; to be dealt with openly and honestly; and for bodies to demonstrate learning from when things went wrong or standards needed to improve.

59. The overall principles set out in Putting Things Right chime closely with the recommendations made by Robert Francis following the Mid Staffordshire Inquiry as well as the more recent report by Ann Clwyd MP and Professor Tricia Hart into the complaints process in NHS England.

60. However, it is clear that despite the intentions of the guidance and some evidence of impact through increased awareness and numbers of complaints, there have still been issues with its implementation and experiences across Wales. Themes that constantly emerge from patients dissatisfied with the process, as well as other key stakeholders such as the Public Services Ombudsman for Wales, include:

- The receiving of a simple apology;
- Not feeling listened to;
- Timeliness in reporting and keeping complainants informed of any delays;
- Lack of clinical engagement in reviewing concerns – viewed as a management process;
- A lack of openness and honesty;
- Little evidence of learning;
- Lack of accountability when things go seriously wrong.

61. These themes have been taken into account in terms of the current review, testing current experiences and promoting better ways of working. It is very clear that NHS Wales needs to gain respect and trust from patients, carers and families.

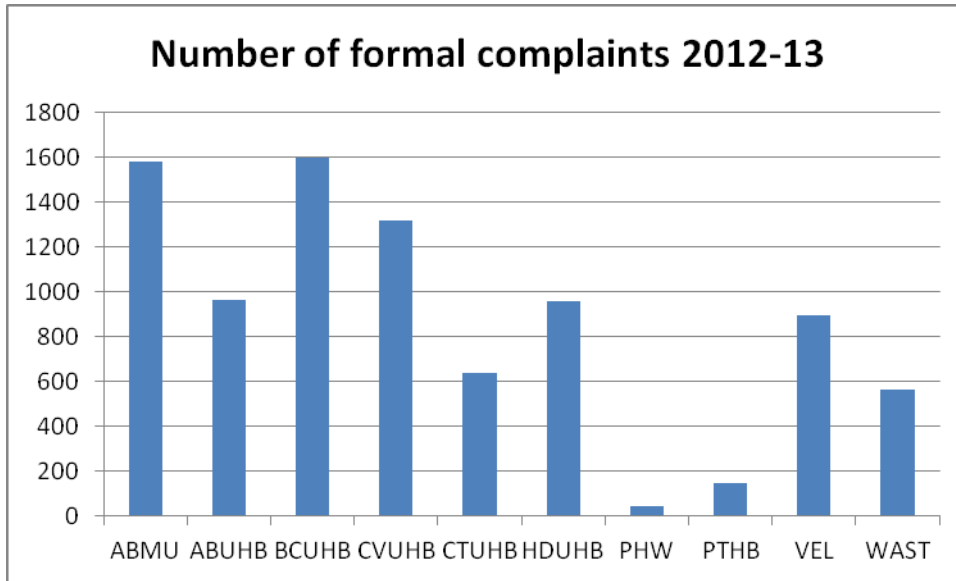
What do we know about current performance?

62. This section sets out some baseline comparative data and performance for 2012-13 which is consistent with the last full year where annual quality statements and annual concerns reports are available for Health Boards and Trusts. As a general point, the review has tried to draw on information already in the public domain; however, from a direct comparison, and despite similar sources for information, the data is inconsistently included and presented. It has been possible to complete some of the gaps to allow this baseline to be established, but it has raised some issues of interpretation. The data drawn from the Public Service Ombudsman for Wales however is submitted clearly and consistently via an Annual Reporting mechanism. The difficulties even within this Review of easily presenting activity and performance data will lead to some later recommendations in terms of ensuring a consistent comparative data set is available openly and easily for NHS Wales and its users.

63. The data provided has allowed an overview to be provided to set some context for this Review that includes for 2012-13: numbers of concerns, responsiveness within timescales, serious patient safety incidents, Ombudsman cases and overall number of claims. In addition, Welsh Risk Pool scores for the same period have been included that demonstrate the progress being taken with standards that apply to the complaints and concerns area, including learning lessons.

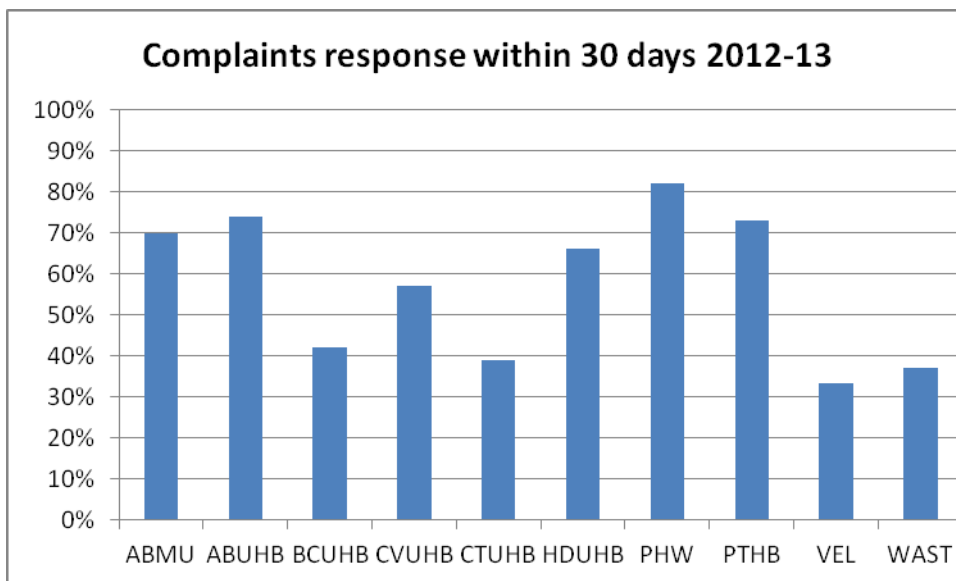
64. It should be noted that the numbers of reported patient safety incidents and concerns received only reflect a small proportion of the overall patient activity and contacts occurring in each individual health organisation and in total at the all-Wales level. Complaints received tend to represent less than 0.1% of the total activity, with patient safety incidents totalling less than 1% of each organisation's activity. Nevertheless, it is critical that each incident is reported and learnt from and that each concern is properly investigated and responded to openly and within timescales. 1% of NHS users represents a vast number of people.

65. This graph shows the total number of formal complaints and concerns for 2012, with variation shown across organisations, some of which relates to the size of organisation as reflected by population and activity.

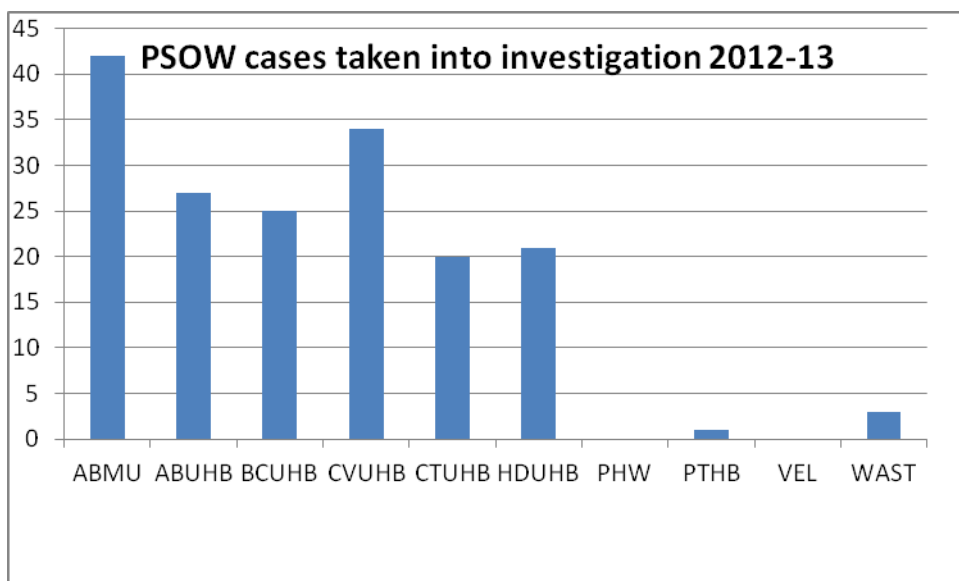
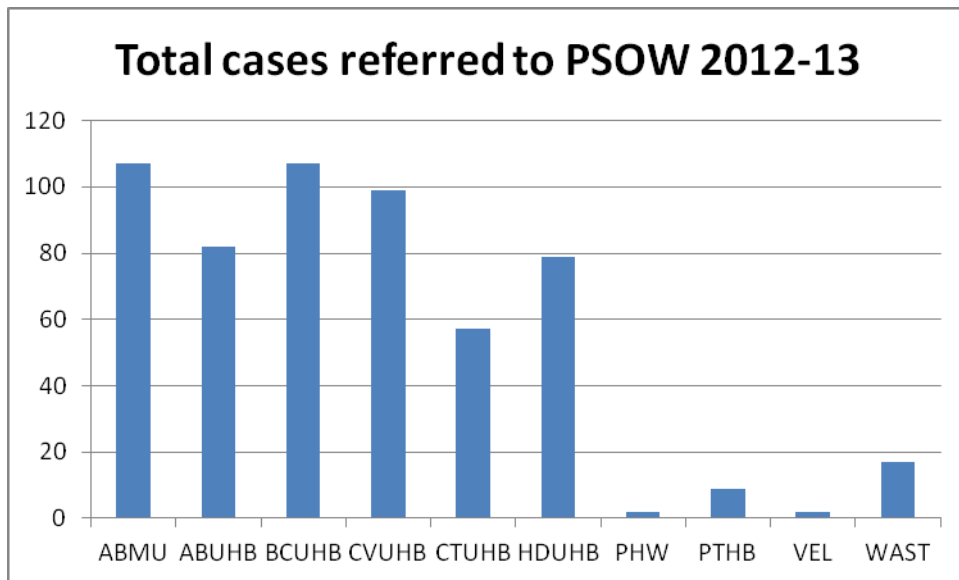


66. It should be noted that within Annual Concerns Reports some organisations have also provided data for informal concerns received and resolved. However, it is not possible to provide this information as a comparison, given the inconsistency of the way in which these informal complaints are recorded and reported across the organisation. This tends to reflect good practice in resolving complaints at source in a timely manner rather than requiring them to be handled at a formal level.

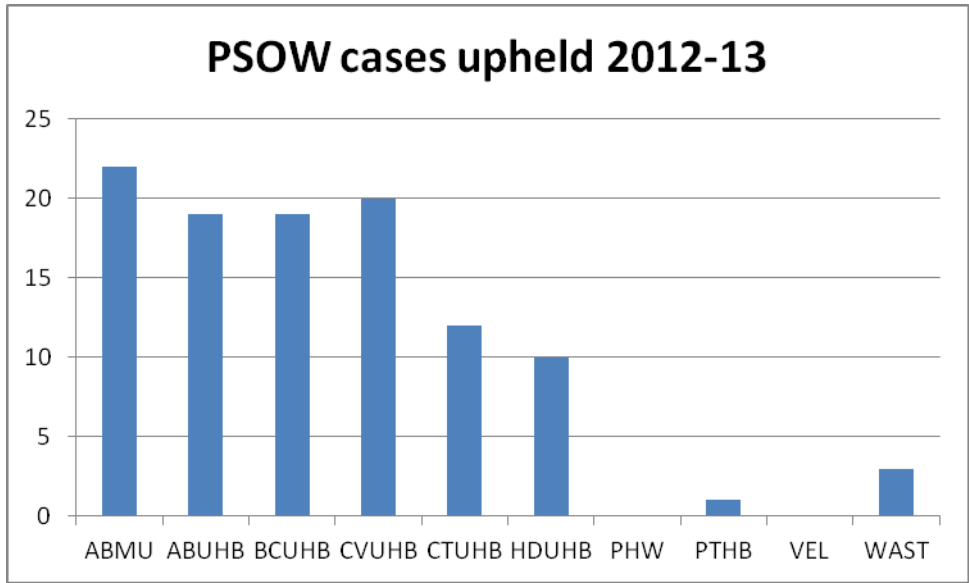
67. The graph below represents the response times for complaints and concerns by individual organisation. The target is for all 30 days and performance in 2012-13 varied from 33% to 82%. Given the complexity of some of the more serious cases, it is difficult to commit to complete compliance in this area as inevitably some complaints will need specific time for proper and detailed investigation. However, based on the data, there are serious grounds for improvement on meeting the 30 days target.



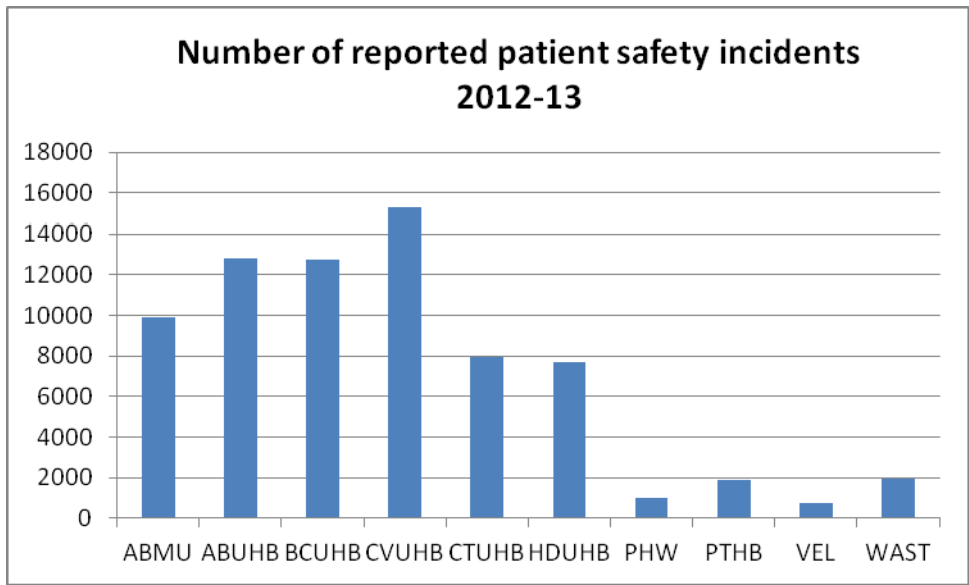
68. The Ombudsman acts as an external office to receive referrals for the most significant concerns although will often choose to refer a referral back for local resolution, before it selects complaints that warrant further formal investigation. This is shown through the two graphs below by the proportion of referrals received to those subject to further investigation.



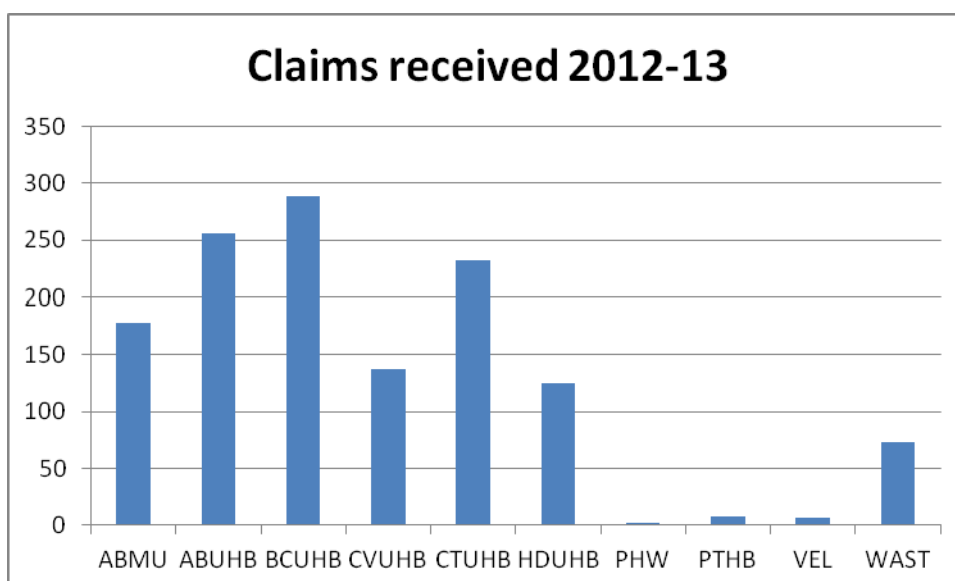
69. The graph below also represents the numbers of complaints upheld by the PSOW office during 2012-13, again which reflects to some extent the size and nature of organisations.



70. An open reporting culture is important in terms of establishing the appetite of the organisation for learning from errors and near misses. The number of patient safety incidents reported by organisations is set out in the graph below, again referring to 2012-13. This will reflect size and complexity of organisation and services. This also provides a useful context for the numbers of concerns received.



71. Also, simply for context, the graph below sets out the number of claims received by organisations in 2012-13. These are the subject of proper legal process rather than directly through the Putting Things Right process, but the legal environment will mostly arise from complaints that have not been able to be resolved.



72. Finally, the table below shows the total Welsh Risk Pool scores for 2012-13 in respect of complaints and concerns management. It provides the specific score for each organisation in NHS Wales as well as the total score for this area, which covers concerns, legal review and learning lessons. Although this shows improvement from previous years, it also shows potential for much better compliance and further local response.

Health Body	AFA 1-13 Concerns %	AFA 14-23 Claims %	AFA 24-27 Learning from Events %	Overall %
ABMU	84.65	87.62	53.08	75
Aneurin Bevan	88.48	93.49	66.92	82
BCU	75.92	84.95	39.08	66
C & V	89.81	91.93	61.54	81
Cwm Taff	94.70	96.96	68.08	86
Hywel Dda	76.83	97.22	69.92	80
Powys	67.42	81.42	23.15	56
PHWT	81.51	97.57	34.38	68
Velindre	88.64	98.33	73.46	86
WAST	89.32	92.48	39.08	73

73. In terms of the areas attracting the greatest numbers of complaints, consistently across the organisations, the following areas attract attention:

- Clinical care and diagnosis
- Delays/cancellations/ appointments
- Waiting times
- Communication
- Attitudes
- Admission/ transfer/ discharge

74. These can vary across organisations, not least noticing the different roles between Health Boards and Trusts and the nature of services provided. These are presented in each organisation's Annual Concerns Report. The highest number of complaints relate to experiences with clinical care and diagnosis; however the majority of complaints will also draw in other areas of concern and often reflect system experiences that will impact on the patient, either through difficulties in access and initial waiting times, moving through local services, poor communication experienced and some reflections in respect of staff attitude. These all depend on how local data is entered and recorded; the general point is that although there will inevitably be complaints arising from poor experience, prospective complaints can be avoided if improvements are made to the system of care.

Drawing in other reports and evidence

75. I was mindful in overseeing this Review that despite a clear NHS Wales context, based on my own experiences delivering innovation and improvement, I wanted to take advantage of broader learning from within the NHS itself across UK borders and also draw on my more personal experience of the commercial sector and what constitutes normal and good practice in respect of customer care. It is already clear that the formal Francis report has had a significant impact on the NHS, and that includes NHS Wales and staff who I have personally met and spoken to. Two years have passed since and these recommendations should not be forgotten.

76. There has been a range of specific responses to Francis, in the UK setting, which includes a good overview from Don Berwick as a formal NHS England response to the challenges that had emerged from the formal inquiry by Francis.

77. I have been interested to note the importance of leadership and culture which chime with the open discussions I have been party to in NHS Wales; there is an openness in NHS Wales for change and improvement and I hope we can enhance the PTR process to allow these actions to be put in place at pace but also with a compassion necessary to oversee the complaints process.

78. I have also noted the specific content of assurances and response from NHS Wales to the Francis Inquiry as a serious inquiry for all of the NHS, despite its England context. It is not my intention to review or summarise Francis. Indeed there have been many informed reviews and commentaries arising from the Francis Inquiry that can better serve this.

79. However, in the context of facilitating better responses to complaints, more effective handling and a focus on addressing underlying shortfalls I would highlight that Delivering Safe Care, Compassionate Care, the Welsh response to the Francis report, made it very clear that NHS bodies must be listening organisations. Listening to patients, citizens and carers and learning from patient

experience is very much expected to be at the heart of the Board agenda. Everyone, at every level, whatever their role has a part to play in ensuring that patients receive safe, effective and compassionate care. This also means having good mechanisms in the system to be able to identify swiftly if the quality of care in any setting may give cause for concern. Complaints, concerns and serious patient safety incidents are a key element in such a system. This, together with other sources of feedback from patients and staff provide a rich source of information to help form a view on standards and quality of care. Boards need to have clear lines of accountability in place so that they are sighted on this feedback in a timely way and can take prompt and responsive action to deliver any required improvements.

80. Health is of course a devolved matter in government. That said, the Francis report regarding NHS England appears to have been taken seriously by NHS Wales. There has been very visible review, discussion and response at all levels setting the improvements we should expect in the context of the learning from NHS England. There are also examples of specific NHS Wales initiatives around safety and outcome, for example, promoted through the Saving 1000 lives campaign, which provide an environment to allow change to happen quickly and with strong engagement with staff.

81. I have specifically welcomed the opportunity to draw in Ann Clwyd's reflections and experience from her review and which was set up in a different context to the Review I have undertaken for the Minister. I find this a very helpful document to draw out recommendations, comments on patient experience and development of system leadership and culture.

82. This NHS England Review, supported by Ann Clwyd and Professor Tricia Hart, drew on more than 2500 testimonials from patients, their relatives, friends or carers, the majority described problems with quality of treatment or care in NHS hospitals. Key points raised which I recognise include:

- Lack of information – patients said they felt uninformed about their care and treatment
- Compassion – patients said they did not feel they had been treated with the compassion they deserve
- Dignity and care – patients said they felt neglected and not listened to
- Staff attitudes – patients said they felt no one was in charge on the ward and the staff were too busy to care for them
- Resources – patients said there was a lack of basic supplies like extra blankets and pillows

83. Within this NHS England Review around 400 people shared similar experiences of either making a complaint or the complaint process, which is useful to shape the areas of concern. I concur with these findings from my own investigations.

- Information and accessibility – patients want clear and simple information about how to complain and the process should be easy to navigate
- Freedom from fear – patients do not want to feel that if they complain their care will be worse in future
- Sensitivity – patients want their complaint dealt with sensitively
- Responsiveness – patients want a response that is properly tailored to the issue they are complaining about
- Prompt and clear process – patients want their complaint handled as quickly as possible
- Seamless service – patients do not want to have to complain to multiple organisations in order to get answers
- Support – patients want someone on their side to help them through the process of complaining
- Effectiveness – patients want their complaints to make a difference to help prevent others suffering in future
- Independence – patients want to know the complaints process is independent, particularly when they are complaining about a serious failing in care.

84. We have acknowledged and been mindful of the recommendations made and I have drawn in this experience in developing my own recommendations. As a checklist, this is as relevant to NHS Wales and I have had the advantage to draw in this work and frame my own thoughts and reflections.

85. Through my own contact with Ann Clwyd, this also provided the opportunity for experiences relating to NHS Wales being able to be shared with me in confidence and through case stories. This has been the first opportunity to draw in and take account of these experiences, which had been received through a different NHS review relating to England, but which I have felt were pertinent to inform our view of the current complaints system and process. These have been included in the later analysis within this report and from my perspective given due weight in the balance of evidence I have accessed and my own assessment of the areas for action.

86. As this Review was nearing completion and in the preparation of the final report, the Minister made available the “Trusted to Care” review by Professor June Andrews and Mark Butler, in respect of quality of care of older people at the Princess of Wales Hospital and Neath Port Talbot Hospital. I was grateful to receive the “Trusted to Care” review on publication and in the latter stages of this Review.

87. It has proved to be a useful checkpoint with the emerging recommendations and I am assured that this local review has qualified consistent themes with my own national review work. It was not intended that the two reviews would complement

each other but have in fact separately developed similar findings and recommendations. The Minister personally asked for the available concerns and recommendations to be considered in this Review.

88. The report has contained specific reflections and recommendations in respect of complaints handling and represented one of its main themes. The themes highlighted that have relevance in this important Review include:

- Awkward complaint handling;
- Slow and bureaucratic response;
- Disappointment in complaints outcome and redress;
- Staff education and guidance;
- Accountability for complaints;
- “Public” voice;
- The availability, use and profile of complaints data at the Board level.

89. Some specific reflections chimed with emerging concerns shared within this Review. I have reviewed and aligned the more detailed recommendations within my Review and tried to accommodate these as requested by the Minister.

CHAPTER 5: REVIEW PRINCIPLES AND METHODOLOGY

Methodology

90. In order to gain understanding of the issues facing the PTR scheme I have divided the three months review roughly into the following sections of investigation:

- Assessing the differences from its inception three years ago to its current status and operational standard today. Has it achieved its basic goals? Has its infrastructure been correctly invested in? And is it delivering results in accordance with the original remit?
- Learning and searching by actively visiting the hospital wards, services and establishments to meet with patients, clinical and medical staff and the teams who support patients through providing the many services of the NHS. Understanding their working environments and how they interact with patients and their families or carers.
- Following the process of a concern or complaint from inception to closure through the Putting Things Right process to establish how visible the complaint system is, how easy is it to use and access? Is it suitable for use by those of all different ages, those suffering through illness or bereavement etc?
- Analysing how, concerns and complaints are handled by those who receive them on behalf of the NHS from patients, families and carers. To check if the ambience for expressing concerns and making complaints is viable for those who wish to do so by both patients and employees of the NHS.
- Reviewing the levels of responsibility and accountability around incidents and complaints to find out if levels of openness and honesty and the ability to speak out without retribution or malice are enhanced or locked down by the cultures of the NHS compared to industry.

91. My personal approach has been to have as much contact as possible in a very short time with a range of individuals, groups, staff and stakeholders. I have attended 56 individual and group meetings, visited a total of 8 Health Boards or Trusts and had contact with over 600 people, including staff and the public, through this process. In addition, I have also received additional views, correspondence and case stories from another 300 individuals through our request for experiences to be shared and also from Welsh letters received from Ann Clwyd's office as part of the NHS England Review.

92. In more detail, this contact has included:

- Meeting with organisations that provide the complainants with help and assistance during the Putting Things Right process such as AvMA, CHCs,

Older People Commissioner, Children's Commissioner and Public Ombudsman.

- Attending organised large scale listening events where members of the public have spoken out about their experiences and hosting individual listening sessions with complainants who have struggled with the usage of the complaints system.
- Receiving and analysing letters from up to 300 complainants (also a review of letters received by Ann Clwyd's office) with a view to deeply understand examples of where the PTR system has let them down so as to formulate improvement recommendations for the system.
- Having interviews with key stakeholders and individuals:
 - Various officers of the NHS management teams including Chair and Board members, Chief Executives and Nursing Directors.
 - Frontline NHS staff including clinicians and complaints-handling teams;
 - CHC representatives and CHC advocates within the Independent Advocacy Service;
 - Senior NHS officers in the Welsh Government;
 - Selected Assembly Members leading on health issues;
 - Ann Clwyd MP;
 - Individual complainants, patients and users of the NHS in Wales;
- Using a small expert reference group made up of stake holders, CHC representatives, AvMA representatives, solicitors representing claimants, Clinicians and PTR operators, to test concerns, reflections and recommendations and ensure that this will genuinely make a difference to improving the current complaints process. This group met three times during the review process.
- The collation of data, reviews, interviews and correspondence into a review report.

93. My approach has placed great reliance on the time, energy and openness of many individuals within and outside of the NHS. I am very grateful to the many people who gave up their time to participate in and support this review of Putting Things Right. I deeply appreciate their candour in expressing their views and their passion, whatever their circumstances, for wishing to make the NHS a better place for all who have the necessity to need to use its services.

CHAPTER 6: FINDINGS, REFLECTIONS AND RECOMMENDATIONS

Drawing together the views

94. The review has provided the opportunity to receive a range of reflections, thoughts and recommendations from a wide variety of stakeholders and interested parties: from the service, through NHS leaders, clinicians and complaints staff; through to politicians; to regulators; to those external bodies involved in the complaints process such as Ombudsman and CHC; to those who adopt an advocacy approach; and finally and importantly for me, complainants with poor experiences of care and the complaints process.
95. I have also had the advantage of accessing a number of patient-focussed group settings with informed individuals and patients, where I have been able to simply listen, reflect and question on issues that have importance to the complaints process.
96. Finally, I have received a rich source of more personal commentaries and stories from patients in respect of poor experience and improvements they would like to see around complaints. I have been, emotionally touched, by having these experiences shared with me in confidence. Some of these have been deeply upsetting and have conveyed families and individuals having been through devastating and harrowing experiences. Often the subsequent complaints process has created desperation to find answers, but as I have observed has also led to exhaustion and the lack of will power to pursue further.

Specific user and complainant views

97. Improving the complaints process requires us to be clear about what the patient expects. In summary this can be presented as follows:
- For them to be at the heart of their complaint process
 - To see that they are dealt with quickly
 - To make sure they receive a human acknowledgement and apology
 - A response that addresses the issue
 - To push for change as patients do not want to see other patients effected in the same way
 - To be given assurance that change has happened
 - To get redress – money is not the only issue in closing the complaint
 - To be given knowledgeable assistance for those who do not know how to complain
98. The Review analysed a significant number of individual experiences (around 300) that were shared by those choosing to contact me formally as part of the Putting Things Right Review. These were complemented by additional individual patient

experiences shared by Ann Clwyd's office on a confidential basis, and without breaching confidentiality.

99. This somewhat, very distressing correspondence reinforced some of the underlying issues highlighted by national reviews and reports mentioned in the earlier chapter and gave strength to the emerging themes from stakeholders and users.

- 12% felt that they had not been listened to through the complaints process;
- 17% commented on poor timeliness in responding to their complaint;
- 4% referred to a lack of clinical engagement;
- Of concern, 18% reported a perceived lack of honesty in their complaints response;
- 11% indicated little evidence of learning and action;
- 13% reflected a lack of accountability;
- 5% simply had a concern around the process itself.

100. In terms of categorising the individual experiences into themes, the overwhelming number shared (44%) related to standards of care and poor clinical practice and treatment. The full breakdown is provided in the table below:

Category	% reported
Standards of care/Poor practice/care	44%
Delays – treatment/appointments	16%
Standards of individual clinician	8%
Inappropriate staff behavior to patient	7%
Communication issues/none/delayed/confused	6%
Customer care	4%
Dignity, respect, compassion	4%
Delays – Accident & Emergency	4%
Clinical detachment from patient/carer	2%
“fobbed off” or perceived “cover-up”	2%
Accountability (inc whistleblowing)	2%
Lost/mistaken records	1%

101. This level of correspondence provides strong insight into the complaints management process from the patient's perspective, based on those who have kindly shared their experiences through the Review on a confidential basis.
102. The quotations below are taken from some of the individual examples of correspondence, but as set out earlier fell pertinent to the tone of this Review and also support the case for improvements to be made.

"If my sister and I had been invited to a short meeting with one of the senior doctors in the days after my mother's death all this could have been avoided."

"No manager was open or honest; everyone tried to cover their own backs..."

"When I was feeling better I phoned the LHB to explain what had happened and asked could something be done to stop it happening again. I heard nothing back."

"I received no notification of how things are progressing, as stated in the acknowledgement letter and no explanation of the now unbearable delay... The onus that comes across is very much protecting of other people and not the patient, which seems the wrong way round."

"There seems to me to be a general couldn't care less attitude by nurses and patients seem to come last."

"...advised of actions that had been taken as a result of her complaint... during a subsequent investigation it was found that the findings were not shared with relevant staff... leaving the family believing the complaint was entirely pointless..."

"I have received perfunctory apologies for errors on the death certificate and failure to speak to relatives. However, there is no indication that either the surgeon or the hospital have learnt anything from the case."

"During this whole period, numerous letters were exchanged – those I received were constantly written by different persons, frequently containing basic incorrect facts and misinformation, requiring constant replies to correct and challenge the false content. There was no meaningful attempt to resolve complaints, and every effort to delay and frustrate."

"My grief... has been compounded enormously by the Health Board's condescending attitude to me as I sought answers... They have continually stonewalled me with unbelievable platitudes and lies and have comprehensibly demonstrated the culture of deceit that is endemic in the NHS. It has taken me 4 years of fighting to uncover the truth..."

"I felt like I had been treated as a number rather than an individual. I was promised that the LHB would learn from it and prevent a reoccurrence. This clearly has not happened which tells me that the only way the NHS will learn is actually through litigation, rather than complaints."

"We feel its wording (letter of apology), how it's been set out on the page and its presentation as a badly photocopied, photocopy, shows their reserved annoyance, that we had had the audacity to have troubled them by complaining. Our purpose was to make things better for others..."

"The last communication from the hospital sent to me last November 2013 said a review was being held and they would contact me in due course; I am still waiting!"

"...but no one ever learns."

"I found the complaints procedure superficial with no acceptance of any shortcomings in NHS procedures or their implementation."

"...it was never about getting money for the problems...my only aim was getting his son help."

"The complaints procedure is, in my experience a sham. Justified complaints are not welcome and no-one is interested in patient experience or offering an adequate service."

"An apology from him (the doctor) at that point would have diffused the situation."

"..many, many months after the targets for responses to complaints had passed, I got replies of sorts from the different authorities, but nothing was going to change."

"I have submitted formal detailed concerns with systemic failure, including their complaints system, multiple times and they have in each and every occasion, ignored my complaint."

"People are afraid to complain in case they are denied care."

"It is now the 10th April, this process has now been going long enough. Still no letter, it seems like delay after delay. I would appreciate some action on this matter and pretty fast."

"Having been through the complaints procedure...an independent review and the Ombudsman, recommendations were made regarding poor care; this left me with doubts as to whether or not the recommendations were implemented and lessons learnt which is why I contacted the Patient experience Team in

the first place.”

“On approaching the nurse in charge numerous times as regards her situation I was fobbed off.”

“...still waiting to hear... 18 months later. Complaining to the staff who caused were causing the issues is not an easy thing to do, and certainly in our experience made the rest of the time on the ward very uncomfortable...”

“...they prefer to deflect any complaint and deny any responsibility and prevent a complainant in pursuing the complaint”

“...the investigation was cursory and ineffective and they had simply quoted the recommended agreed staffing levels to me without regard to the actual attendance.”

“The complaint has taken nearly two years to get to this stage...”

“My husband died in 2012 and I am still pursuing the treatment he received...”

“I feel the issue was unresolved. No proper explanation ever received.”

“I am not seeking any form of compensation...I merely wish to ensure that in the future the standard of care...does not warrant such a litany of failure of observation and inaction.”

“After applying and paying for ...medical notes it took 73 days for them to arrive...The investigation and the response I received was full of fabrication and the focus was taken away from the facts...and shifted to accusing myself, my wife and family as causing trouble and displaying unacceptable behaviour which was totally untrue.”

Developing the themes

103. The purpose and tone of this Review has been to take time to meet and listen to, in person and via correspondence, as many people as possible and although not possible to include all correspondence, I thank those people who have taken the time to support the Review with details of their experiences. I think the quotations speak for themselves and provide adequate evidence to invoke serious improvement.

104. I have tried to draw all of these different sources into my general comments and observations and ultimately inform actions and recommendations. My own reflection is that there are more similarities than differences in these views and this section sets out some of the areas that have been highlighted. I believe that these together represent a powerful case for change. Many of the themes show

that it is possible to use and improve the existing PTR guidance and implement consistent approaches and change, rather than be distracted by rewriting the PTR guidance.

105. At the same time, an emerging view is that we do need to reclarify the PTR process in simple terms, not least as I reflected earlier, that there are difficulties to simply understand how the complaints systems and support available works. This needs to pass the test of lay users and patients, not by those immersed in the detail!

106. Inevitably, as I said in my personal introduction, the nature of a formal complaints review is that it is likely to take on a negative perspective as I have focused on what has gone wrong both in care and process terms. I am also mindful to make the point that although there are many examples of consistency in comments received across stakeholders, these themes have been drawn from observations and reflections made, whether perception or fact. From an action perspective, whether fact or perception, they have to be addressed.

107. This section I hope comprehensively captures the many reflections and findings raised with me through the course of the Review. I hope it will chime with those who shared their personal observations with me, from the many perspectives I received within and outside of the NHS. For ease of presentation, I have set these out in respect of the Minister's four objectives for the Review contained within the terms of reference.

- 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 within the process;
- Identify how the NHS in Wales can learn from other service industries; Consider the wider cultural 'patient' service ethos and how staff are supported to deal with patient feedback;
- Identify how the NHS can demonstrate it is learning from patient feedback.

1. Review the current process to determine what is working well and what needs to improve

Themes identified by stakeholders and users

Easy to access and use

Speaking and meeting

108. A number of comments were received indicating that if the complaints team – or extended team – could simply pick up the phone or meet them actively, the level and nature of complaints would reduce. There are examples of this already working across NHS Wales, notably promoted by those organisations that have adopted PALS teams as an active response. This again reinforces taking a proactive stance with much contact, but with the intention to avoid a deteriorating set of relations and more difficulties in the future. There is a reward for time and attention for all involved in the process.

Making things simple

109. Irrespective of the size, number and complexity of organisations, there is a strong requirement for the complaints system that patients and families find themselves in to be streamlined and simplified. Despite good intentions, PTR has developed more red tape within the complaints system, which is more a challenge to the implementation that has taken place than the specific guidance. Process has become predominant sometimes in the face of common sense approaches. However, from a regulatory or external perspective, if process isn't followed in cases that ultimately come under external scrutiny there will inevitably be criticism.

Meeting timescales

110. Investigations are often not being completed within the 30 days timescales set by PTR. 30 days would appear to be a reasonable expectation to expect a full and informative response, given that time passes very slowly for those actively making complaints. Cases that can be responded to earlier and well within these timescales should be. PTR was introduced to make the process shorter and easier for complainants to negotiate; the current way in which the process is working is conversely emotionally exhausting to complainants. Some complainants give up and state that they no longer have the strength to continue. This clearly needs to be addressed and improved.

Protracted process

111. The quality of investigation varies across the health boards. A more centralised department for investigation and redress may provide more robust investigations than those carried out within departments and localities. Within the

current system, more complainants escalate the complaint to the Ombudsman. The Ombudsman at present does not normally consider redress he usually only identifies breach of duty. This means that the complainant has to work through a very protracted and unsatisfactory process. Even engaging the Ombudsman's complaints process can be quite lengthy before finally having to seek legal representation on the basis of the failings identified by the Ombudsman.

Getting help to access

Visibility of patient/family support

112. Some of those involved in the review process reflected whether there was a chance to align some of the broad patient support to make it available as an alliance and to be visibly available eg in main receptions of hospitals; this could extend to bringing together CHCs, external organisations (eg AvMA) and local patient advocacy services such as PALS or members of the complaints team.

A confrontational system from the outset

113. The system, contrary to the stated intentions of PTR, in the worst examples can operate in an adversarial manner from the outset. As stated earlier, most complainants are looking for honesty in any investigation and a commitment to address any areas shown to have failed or fallen short. The process seems to operate with an assumption that every case will revert to litigation when a more sensitive approach may actually avoid this.

Active contact

114. Communication with complainants throughout the process is patchy and non-informative. It is often left for complainants to chase for up-dates whereas the requirement is for health boards to provide up-dates unsolicited. This simply adds to anxiety and also starts to deteriorate the relationship with the organisation.

There are individuals who will need support to navigate the NHS system

115. A particularly strong view was received from the Older People's Commissioner for Wales in respect of supporting older people who suffer poor health but do not find it easy to understand the NHS systems or the complaints process.

Improvements to complaints process

Putting Things Right guidance

116. A general set of views that the intentions of PTR remain sound and most comments are not seeking a change in the guidance. However, there is a request for simple description of the system and for the implementation, responsiveness and constancy to be addressed. *The need for this change is consistently agreed by complaints handling members of staff.*

117. Many staff members working in complaints are making best efforts to provide a responsive service with increasing volumes of complaints and higher expectations. It has been evident that the views expressed by many of the staff members handling complaints all over Wales, and in specific advocacy roles, are similar.

Learning from Mid Staffordshire

118. There is a lot of information, data and scrutiny around and across the system. There is a need to join these and perhaps better coordinate their use and learning on an all-Wales basis. However, information that triggered action in Mid Staffordshire is generally already available and visible in NHS Wales. There may be advantages to raise complaints explicitly as part of performance reviews in Wales as a priority target.

Sensitivity in the face of the most difficult complaints

119. In the most difficult complaints, families are not just raising concerns, they are responding to a tragedy in the most emotional of circumstances. The fragility of families in this environment must be recognised and it requires a specific set of skills to provide support, even as far as bereavement support and offering this actively and individually. Trained eyes can see family and patient distress.

Members of staff move a lot from operational areas

120. There are concerns that delays can be experienced due to the way in which staff in the NHS inevitably move around quickly, often with little notice. This is most apparent through the way in which junior doctors as part of their training experience will move across rotations to different specialisms, different sites and indeed different organisations.

Lack of ownership

121. Some experiences have been outlined which show a lack of ownership and accountability for resolving a specific complaint whether at the highest level or down the structures. In these circumstances it can place a great burden on complainants to constantly chase for information, status and response.

Some organisations are struggling to deliver their response to complaints

122. We need to continually ensure that Health Boards and Trusts are fit for purpose in their complaints response. There is a need to ensure that clear leadership is in place to drive and oversee an improved local complaints process; there is also a need to ensure organisations commit to the right infrastructure for the number of complaints received.

Resolving complaints at source

123. Complaints in the NHS will of course emerge from all areas of service, but finding ways to be available to resolve complaints quickly at local operational

levels in the face of the ongoing priorities of delivering care and treatment can be difficult. The NHS operates in a busy environment, with increasing workloads and many clinical functions taking place at the same time. Many complaints could have been avoided by some prompt contact and communication at the outset, often looking for advice and contact with clinical teams. There are some examples of innovation across NHS Wales for example, time being set aside by ward managers to be available to families and finding the number of complaints significantly reducing or even disappearing.

Breaking down the complaints process

124. A number of commentators said it would help to break down the complaints response and timetable into timings within the 30 day target, in terms of ensuring case notes were made available, that there was early contact with the complainant, that a prompt and early clinical review of the seriousness of the case took place and that investigations are completed well within timescales.

Visible senior contact

125. Complainants often wish to meet with senior staff in order to ensure that their complaints are heard at the right level. This is not always possible and meetings where people from directorates are facilitating often break down and leave the complainants upset.

Categorising complaints

Categories of complaints are important

126. There is a difference between serious complaints, concerns and enquiries. The system needs to be able to distinguish these and graduate the different concerns. Specifically this is to ensure that the most serious and difficult complaints attract the highest level of attention and expertise without compromising the ability to routinely respond to other complaints and concerns.

Infrastructure

Getting complaints wrong takes more time

127. Often a reason why complaints are misjudged or mishandled is down to available time to prioritise the complaint whether at an operational or complaints team level. However, most of those with experience state that in fact a mishandled complaint requires more time afterwards as well as creating a more unstable set of relations with complainants. Not addressing complaints actively upfront is a false economy.

Not everything is about resources

128. There will always be a need to align resources to complaints as a significant priority for Health Boards and Trusts; a current criticism is that generally demand from complaints and the local capacity to respond seems to be out of balance.

However, a lot of helpful observations and comments have been made that suggest it is partly about using resources more effectively and in a proactive manner. Sometimes the task is simply to reorganise and reallocate resources to complaints as the priority and with a growing involvement of clinical staff. There are choices to better use the resources you have. If complaints are a priority, organisations need to execute their available resources in line with this rather than use resources as an excuse.

ICT Infrastructure

Improving the complaints IT system

129. There have been variable comments on the effectiveness of DATIX as the complaints system. Although many felt the system was able to discharge its core role, it has been described as inflexible and at times cumbersome. Front-line staff particularly commented on difficulties in using it easily as a reporting system.

Incident-reporting

130. Successful organisations place great reliance on ensuring that different levels of incidents are reported actively to ensure system learning and avoidance of the most serious complaints. There are significant numbers of incidents reported via DATIX so the system is being used; however, generally people would expect a higher level of incidents to be reported. There is however concern that increases in incidents are seen as a poor reflection of service, when best practice would say that the better organisations positively seek to find out the highest number of incidents to be able to prevent them reoccurring.

Centralised complaints intelligence

131. It is surprising that there is no central repository where all complaints being handled across Wales can be shared and stored consistently. Information is retained within the boundaries of individual organisations, so this limits the ability to share good practice, effective templates for responses, mechanisms in place to create better relations with complainants or indeed reconcile the content and nature of individual complaints responses. At a summary level, the DATIX system is able to capture a level of information available drawing the local information into a national database.

Courteous correspondence

The tone and nature of correspondence

132. There are opportunities to share good practice and improve complaints templates. Even simple complaints can attract a complicated response over many pages responding to more than just the complaints issue. However, difficult and complex complaints clearly need to convey a very detailed investigation with clear statements of response and apology. There is a general view that

complaints response tends to steer away from simply apologising for actions and interventions that have gone wrong, which for many complainants represents a simply courtesy.

Regulation

The role of regulators

133. There has been a request to better describe the overall complaints system, including the support offered by regulators. However, there has been a specific request to set out the role of HIW and other regulators within the Putting Things Right system. An effective complaints process will require an effective regulatory system to be in place directly for complaints, but also in terms of other regulatory responsibilities such as escalation processes.

Frequency of regulator engagement

134. If HIW is formally only inspecting on a limited basis how can assurance be obtained that the relevant organisations are actually innovating themselves effectively, from the complaints or any other data, being offered up by patients and users or by internal groups via the staff review and appraisal systems in use? The NHS is subject to a whole range of routine and annual audit checks; however, accountability in this area needs a clear regulator. It is important that this external independent activity is carried out more frequently as the bigger or more diverse an organisation, the higher the risk levels become.

The role of elected representatives

135. It is important to acknowledge the role that AMs and MPs, play in terms of facilitating and raising local complaints. And, helping constituents navigate their way around the organisational structures and complaints process. Some involve CHCs; others refer directly to Health Boards and Trusts. There has been a potential danger to create an alternative system for AM enquiries on complaints and the PTR process in terms of speed of response. However, clarity on the nature of an enquiry on behalf of a constituent as distinct from a formal complaint may help. What is clear is that all Assembly Members have significant insight and experience into complaints and any NHS system needs to be responsive to this route for patient complaints but within the PTR process.

Redress process

Legal assessment and experience

136. Complaints and litigation are connected within the overall process. Putting Things Right provided a bridge between the two areas through the development of the redress process, intended to fast track some of the lower level legal complaints. There has been some challenge as to whether the NHS can ever

hold the requisite legal experience to properly determine internally redress levels or liability.

Ensuring redress does not just become an alternative to good complaints

137. There is a danger that the introduction of redress as a legal mechanism within the complaints process, means that organisations move to settle in a legal context including offers of compensation, rather than respond to the simple requirements of showing a serious response to a complaint. There have also been some examples of a move to a redress arrangement inflaming the relationship and discussion taking place between organisation and complainant if not explained appropriately. Although redress is speedier than the normal litigation process, it does extend the normal complaints process deadlines.

Liability

138. Views have been expressed that cases that raise issues of liability are not being addressed appropriately. The requirement is for an initial assessment of the case to be carried out and a response provided within 30 working days stating that the matter is being looked at under part 6 of PTR. This has the effect of stopping the clock with respect to the clinical negligence limitation period. In practice Health Boards and Trusts are routinely taking 6 months or more to respond to a complaint where the matter does not raise issues of liability – this is a breach of the regulations. Where issues of liability are being investigated often an interim response is not provided. Organisations appear hesitant of admitting where further liability investigations are being undertaken. The spirit of PTR is openness and this currently is not always in evidence in the way in which complaints are being handled.

Abuse of redress

139. Some concerns were expressed that in the way the guidance is established those representing complainants legally can use redress to formalise the case without their own work and then subsequently represent the case. This means it can feel that complaints are inevitably going to be drawn in to a legal process.

Redress thresholds

140. The threshold for looking at a matter under redress is in practice being set too high. The wording of the regulations is that an interim response ought to be sent where there is or may be a qualifying liability in tort. In practice interim responses are only sent if ever where health boards consider that there is a qualifying liability in tort.

Central legal support

141. This central shared service is under pressure though the amount of redress complaints it has to handle and conclude. The end to end management from complaint registration, completion docket, phone calls and negotiation using

individual records is itself a labour and can be very lengthy and not hit timescales.

Addressing primary care

Involving primary care

142. In terms of primary care, some views were received from those working within primary care that PTR and redress is very suitable for hospital-based services but not for an independent contractor part of the NHS such as a GP practice. Although there may be lifetime service from GP to their patients and families contact with them is usually very short and not elongated like a hospital. GPs can feel distant from the local Health Board structures and from the broader NHS processes in place. PTR needs to be sufficiently flexible for the nature of primary care.

Dentists

143. There was a perception that complaints that involve dentists often result in patients being deregistered. This may be because the nature of the dental contract does not require a commitment of on-going patient care. Dental care is given on a treatment by, treatment basis. In the current system this makes the patient vulnerable where they might wish to express a concern in respect of their treatment.

Investigation expertise

The development of investigation expertise

144. There has been less call for this in the past in terms of previous reviews and changes to the complaints process. However, a consistent theme during the course of this review has been a focus on centralised investigation expertise, locally within the organisation, but with an emerging discussion about whether focus could be given at a national level across Health Boards and Trusts.

CHC

Redefining the role of CHCs

145. It is clear that CHCs have an important role to deliver in respect of complaints; they have an anticipatory role in terms of acting on local environment and reporting on concerns; they have a role to listen and facilitate local commentary and observations on services that are struggling; finally they have a role to deliver the CHC independent advocacy role, recently subject to a national review. CHCs deliver this independent advocacy service in line with the function outlined in the NHS Act 2006. There is an emerging view that they have not been given all of the tools to deliver on these and are disempowered to discharge better challenge to

complaints; there remains a need to accommodate the recommendations of the Longley review, not least as they would improve the role of the CHCs in the complaints system. Some concern has been expressed that CHCs are not distinct enough from the local health organisations they oversee; indeed in one of the complainant meetings that took place, many of the complainants attending were unaware of the complaints and advocacy role of the CHCs which represent two different functions, but with the advocacy role acting independently. The awareness of the advocacy service is not high enough possibly because it is lost within the CHC system and its other functions.

My reflections

146. Generally, Putting Things Right has been well received as guidance and its intentions remain sound in terms of driving a more responsive complaints process. However, the concerns relate more to how PTR has been implemented and the variation and inconsistency in place across Wales.
147. The first comment I would make about the current process is that it can be difficult to understand and there is a need to simplify the understanding of the guidance, not only for complainants wishing to use it but also for staff seeking to respond. It should be understood that people may want to complain and it should be made as easy as possible for them to do so. Rather than looking to revise the guidance, there is a need to describe the process in simpler terms and show how those who wish to complain can navigate the system inside and outside the local Health Boards and Trusts.
148. There is nothing worse than trying to complain when you do not know how to complain. Most people who come into contact with the NHS for example would have no idea of how to express a concern to it or make a complaint about it. Unless there is help at hand to assist them with this process it can result in people spending years trying to navigate one of the most immense and confusing organisations. At a time when you are recovering or suffering bereavement you need help and assistance to make your point and this should be provided by the organisation in an independent, kind and thoughtful manner.
149. There are some very motivated and capable people working to respond to a high volume of complaints that have inevitably been generated from PTR and NHS issues following its launch in 2011. From my own perspective, there has been an under-estimation of the infrastructure required to maintain a professional, comprehensive and proactive level of response to all these issues given the number of complaints actually received and the process and expertise required to facilitate this. There is a need for more resources, and greater seniority notably around clinical expertise, to be targeted at the complaints function. Whether this is new resource or redirection of resource is an area to be explored further across NHS Wales and the Health Boards and Trusts; it is clear

that some organisations have already had to recognise this and have seen a benefit from revising the way they deliver their complaints function.

150. At the moment the system is treating all complaints, whether low level enquiries or the most severe complaint, as part of the same process. There is an opportunity to respond more quickly, but still professionally, to the lower level complaints and to free up some time and resource for the proper investigation of these more serious cases. A clear understanding of the grade of complaints alongside the best response to this would help a more responsive system in overall terms. The system of levels is much too complicated within PTR and could be reduced to fewer stages. This in itself merits serious discussion, to be discussed with groups with interest.
151. There are concerns that investigations are variable, depending on the expertise of the investigating officer and the local experience and establishment of the complaints teams. The greater the expertise, the better the quality and outcome of the investigation process and certainly for the most serious complaints, there is a case to be made for a different approach to investigation teams, potentially located centrally as a core role, but also with the potential to be better supported across NHS Wales.
152. The real area to impact on the management (and indeed avoidance) of complaints is being prepared to use and support your frontline staff and services. Being on the frontline to handle concerns and complaints from patients and users in a humble manner is the true and purposeful mission of those who really want to help others, learn about what is wrong and to step up to the bar and lead change for the better.
153. It should be possible to engage and lock all relevant parties into a complaint at the same time. This means that investigation can be quicker and of a better quality and reaction times to issues dramatically reduced with the innovative outcomes pushed into practise much sooner to prevent repeat incidents of the same types.
154. A central database across NHS Wales provided through the DATIX system is a good idea for providing a consistent reporting base for incidents and complaints. It is important to acknowledge that this is a system that is beyond just the complaints process through its inclusion of incidents, but this is a positive opportunity for learning and responding to themes and occurrences. However, most staff users involved in the review, have complained that it can be a lengthy and cumbersome way to register an incident, particularly at the level of a busy ward or department.
155. The DATIX system is generally viewed as a risk management system as it is not designed as a complaints management system. However, it would be better to be used as a key intelligence management tool and, despite problems, it can

operate in this way. Some technical issues have been highlighted which if resolved would simply make the system more user-friendly even though it is being used consistently and to a good level across NHS Wales. All concerns should be noted into the DATIX system for trend management.

156. Health Boards and Trusts have developed different measurements of PTR timescales, sometimes based on historical timescales for response, or based on breaking down the acknowledgement, investigation and response phases. Although intended to support complaints responses, in practice this has led to a more complex process in implementation that is often leading to complaints responses being issued outside of the 30 days target. Systems have grown into their own way as handlers have fallen back into old ways or modified the system to meet their own requirements. There is a need to concentrate on standardisation and a consistent set of expectations set out by PTR so complainants have the same expectations across NHS Wales, irrespective of the organisation.
157. A Slim, Standard, Same, Speedy operation needs to be adopted to ensure that quality of investigation becomes the standard that all Boards should aspire to. If pairs of hands are limited, then resource must be well managed by enabling efficiency through better platforms. A complaints team must consist of operators with skills in quality and compassionate email and correspondence writing, legal advisors and clinicians (including medical staff) on the teams working in a one-team concept. There should also be team members who can respond quickly on the phone or through bedside visiting once a concern has been elevated to complaint.
158. It should also be the case that senior nursing or medical staff should be fully trained to handle concerns in the wards and at the bedside without delay. It would also be a beneficial period of time for new clinical staff to be rotated in and out of the complaints centre to learn about complaint handling (no different to new starters in companies doing the rounds) I am sure that this would share knowledge and help to continually innovate the complaints system as well.
159. Speed is not the only issue; the quality of the complaint handling is also extremely important. Dealing with responses in line with the category of complaint highlighted above may make this timely for complainants. Correct and truthful information, correct and honest answers to patients, families and carers, together with quality investigative handling will increase satisfaction with the process and even reduce overall costs through the eradication of inconclusive debate with patients and their carer's and families.
160. The PTR process applies to primary care as much as it does to Health Board and Trust direct services. However, whilst primary care providers fall under the PTR remit to the same extent as secondary care there is no evidence that this is

fully appreciated. Some complainants have received local complaint leaflets that are completely at odds with PTR. There are some concerns about deregistration from GP practices when a complaints process has been followed.

161. Where the Health Board is invited to exercise its discretionary powers to investigate primary care providers sometimes the Health Board forwards the matter for investigation by the contract holder but does not provide the complainant with reasons for its decision nor advise the complainant that they are entitled to have a Health Board decision not to investigate to be considered by the ombudsman.
162. It is important to be able to appropriately revert to a legal process. To have patient safety and justice you need to have litigation. This means challenging the process legally and independently then learning from the challenge and applying change and proof of change. The NHS should be routinely informing of complainants' rights to legal support and independent help. There have been some comments that the NHS is not best placed to provide legal guidance through the PTR redress process and beyond. As a result reasons for not getting redress are not being clearly explained as to why you would qualify for it or not. The process should have some provision for independent clinical advice, which is already being used in some of the best examples in NHS Wales.
163. There is sometimes a governance need to recognise when there is a need for a more significant and independent investigation or process to be used. This is clearly only ever going to apply to very significant and serious complaints.
164. Lower grade and younger complaint handlers are fearful of speaking with more senior clinicians and medics so they tend to do as they are told and come back later if the more senior person is busy. This causes delay in bringing the complaints times down.
165. There should be an expectation that Boards use their Board machinery, at both public Board meetings and through sub-committees notably the Quality and Patient Safety Committee arrangements and assessments of risk. This should also easily allow for links to patient experience mechanisms. It seems that the natural default for patient experience and care is via the Nurse Director on behalf of the organisation, but not to be exclusively responsible. As a minimum, there needs to be clear professional leadership in place, requiring close work across the respective professional leads around the Board table. However, quality, safety and compassion are the remit of the whole Board and of the whole Executive Team.
166. NHS redress is not provided in England. Wales has innovated this process. There is a need to revisit the regulations as they appear to be too complicated for lay use. There is a need to reduce levels and build in another level of independence before the top level. It is sad, that a system that is there to give

patients redress after a mistake, has become such a regulated and complex procedure.

167. Boards should examine the flow charts for complaints processing, checking the system for how many touch points a complaint goes through and how the analysis of incidents and complaints is taken up and used to innovate. Are there too few complaints points and how is this data collected into one place in the NHS? In my view, improved quality complaint and incident handling will save money in the end.
168. Formal correspondence is an area of concern in the NHS, but also an opportunity for rapid improvement. AMs for example, have mentioned that one of their biggest areas of complaints is regarding the manner and tone of letters received by their constituents. It is not good to receive a matter of fact letter that does not convey respect for the circumstances or acknowledge your point of issue. It can appear particularly insensitive if the complainant is also distressed or trying to overcome bereavement. Some examples of letters shared with me have been quite insulting to the recipients and also uncompassionate, although this is not always the case. The letter-writing stance of the whole board, not just in respect of complaints process, should be reviewed and determined by the Board in terms of the personal contact it wishes to make with its patients. Poor letter writing just inflames situations and feeds the complaints machine. The receipt of a standardised letter can make it feel immediately that there will be a defensive approach to the complaint raised. Certainly this is an area that needs review and leadership.
169. Develop an internal training system that would develop the people in the complaints teams to a professional level with high morale and who were proud of their contribution. I have certainly come across committed individuals doing their best within the existing infrastructure, but I have been left feeling that complaints teams can sometimes feel that they are overlooked and to the side of the organisation. This core training would be placed into the organisation to create good atmosphere and a desire for staff to happily and enthusiastically handle concerns and complaints end to end. Importantly, this would help allow for a real focus on care and compassion.
170. Unfortunately, the Putting Things Right guidance has created somewhat of an industry, although my own assessment is that this is not what the guidance intended or expected; large complex organisations can often find their own way of creating bureaucracy in any implementation. I advise that there is a need to clear out the bureaucracy in the complaints system and reduce the number of contact points and departments needed to be involved in the complaint process. This can either be done by making a single process across individual organisations or by taking advantage of the opportunity to create an NHS Wales

identity through better collaboration and central planning across the respective organisations.

171. There is a need to implement processes that makes complaining easy and this is necessary through both visible internal and external mechanisms. This means using new technology through the internet, emails and social media as well as advocacy points, physical boxes on departments, clear posters showing how to complain and visible patient information leaflets. This opens up the number of opportunities and contact points for complaints and in a customer service environment where every complaint should be seen as a gift it gives every opportunity for concerns to be expressed but to achieve a positive response and change.
172. A real challenge to the NHS in respect of creating an equivalent customer care environment is to find and embrace a manner by which every individual having a contact with the NHS in Wales can have the opportunity to make comments, positive or critical. Given that NHS Wales has in excess of many million contacts each year this is a tall order, but this would represent real innovation and would represent NHS Wales leading the way in customer service. This moves patient care experience beyond snapshot audits, which of course will continue to have their own value in a range of different methodologies for capturing experience. These types of initiatives and approaches make the complaints ethos positive and visible and, in my view, give the public the confidence to be able to complain, ask or speak to the relevant contacts in the organisation.
173. I have seen excellent innovations such as the development of Patient Advocacy Liaison Services (PALS), although these are available to different degrees across Wales. Starting a PALS system, or an equivalent approach, can act to help all, whether staff or patients, to overcome the complications of complaining. Of course the critical focus here is in supporting patients, families and carers through their care experience or subsequent complaint. We need to be realistic about the emotions facing patients and their families when receiving care; even the easiest complaints system will be considered insurmountable by those who are at low ebb or not confident in the different surroundings and conditions they may find themselves in. It must also be remembered at all times that many patients, but especially the old and young, are sometimes not capable of making a complaint. It may be that they do not know how to or the correct provision is not made for them to do so; but this may arise from the fact that they also may not be courageous enough to pursue a complaint or feel vulnerable if they pursue a concern or complaint.
174. In a short time I have gained much insight through individual, group and ad-hoc meetings I have attended where I have been able to listen to and reflect on the direct experiences of those who have had concerns and complaints against

the NHS. I can only advocate that Health Boards and Trusts in NHS Wales should have regular opportunities to meet with patient support groups and liaise with those who have complaints and experiences to share. I have heard the majority express that they are looking for confidence and assurance that changes will be made further to their poor experience; I am also aware of some very difficult individual cases where it feels inevitably concerns will revert to a much higher and probably legal level to find redress that satisfies the family. The benefit of a more open and routine approach to listening to patient experience and complaints in particular is that it allows a different relationship to develop, allows some respect to emerge for different perspectives and allows better communication of the serious actions that are being implemented as a result. I have sensed some hesitancy in NHS Wales to act in this manner creating a much more active set of relationships. I have commented previously on the use of language such as “they” and “them”. However, the development of these more open sessions and the introduction of innovation such as complaints clinics are to be welcomed.

175. I have seen initiatives whereby if complainants are requested to attend meetings with the Hospital they have been offered support from the Health Board via a Complaints Support Officer. Importantly, this has been someone who is seen as more supportive to the complainant, but also is aware of the hospital’s policies and procedure. I believe that patient support mechanisms, building on examples that do exist, like the Patient Advocacy service in individual Health Boards or drawing on the experience of the CHC advocates, but finding the balance of acting with and on behalf of complainants. This may feel like a brave step to take as an organisation, but it does represent the steps that a customer care organisation would take.

176. There is a need to ensure that if Putting Things Right is the core complaints process for NHS Wales that it is delivered in primary care as much as it is delivered in the responsibilities of Health Boards and Trusts. I was concerned in contact that I made with representatives of primary care that it is seen as less relevant to GPs and dentists, and may need to be adapted somewhat to ensure it can be used effectively. At the same time I would comment that I have found it difficult to fully understand how some GPs, acting as contractors rather than employees within the NHS system, believe that they do not need to participate in complaints processes. In the best examples, this is not an issue and practices can fully demonstrate an open and effective complaints process using the Putting Things Right process. In the more difficult examples I have come across, the need for a complaints process has not been accepted well. This is also true when extending the discussion to the way other contractors, such as dentists, operate in respect of complaints. The NHS environment needs to be reinforced in these settings, particularly where NHS work is contractually and financially supported. Complaints systems cannot be seen to be an optional extra; they are

fundamental to any organisation. DATIX is not regularly used in the primary care settings. This must be a flaw in respect of creating consistently reported complaints across the whole of the NHS system.

177. Given the pressures and workload within the current system, we should acknowledge that Health Boards and Trusts have struggled with the numbers of complaints that have positively emerged from greater awareness of the Putting Things Right process and other issues. I have already made my point that the NHS in Wales needs to ensure that the appropriate infrastructure and resource is put in place to keep pace and respond promptly and professionally to the number and range of complaints received. At the same time I have heard from specific organisations that have struggled over time and there is a backlog of complaints that needs dedicated action and focus to clear. I place this responsibility firmly with Boards and advise them to ensure they are aware of any local difficulties and develop a process and timetable by which any outstanding complaints, concerns and incidents are dealt with.
178. I need to offer some comments on CHC roles within the complaints process, whilst recognising that CHCs themselves have been subject recently to a review and subsequent recommendations led by Professor Marcus Longley. I have heard that CHCs can appear to be limited in the powers they possess to genuinely expect change not least further to investigations they have led themselves. The CHC independent advocacy service is genuinely well received, where it is known and used. However, some of the public group settings I attended showed me that for the public the role of CHCs in respect of complaints support is not properly understood. I believe it is possible to strengthen the CHC's role further in this area, given they have a role to act as local eyes and ears in respect of concerns and quality of service. This however needs specific reference and clarification within the Putting Things Right process.
179. I want to reflect on making change happen. There are many expectations placed on the NHS by the public and of course there should be an expectation for good care and quality. However, even while leading this review it has struck me that many seem to know what needs to happen to improve the process, and there is an acknowledgement that resources have not kept pace with the volume and demand, yet often it is only when a crisis point is reached that active interventions have taken place to ensure that an improved complaints process is put in place. I acknowledge that resources are tight for public services; but my challenge is whether there is a better way of aligning the resources to complaints as a high priority, as my assessment is that more time is taken and the cost is much greater when complaints handling has gone wrong.

My Recommendations

Easy to access and use

R1 Putting Things Right must be made easy to access by all once the initial scheme has been explained to the patient, their families and carers. Any receipt of a complaint or concern needs clear ownership to acknowledge once the complaint has been received in the NHS domain setting. There must be responsibility for a response either corporately or within the department itself.

R2 Managing concerns and complaints effectively at source should be a major part of the PTR process. Each ward, department or service should simply provide support and material to allow patients to access the PTR process easily should they wish to do so during their experience. This means providing appropriate help and support to those who may be vulnerable or incapacitated or without immediate carers. There needs to be a proactive routine in place within departments to ensure that this can be collected speedily and acted upon. This should be facilitated by examples such as intentional ward rounding or active questionnaires.

R3 Health Boards and Trusts need to respond to the different ways of communicating concerns not least the use of technology and social media for those who wish to do so. This should include PTR websites, Twitter accounts and Facebook to ensure this is easy to access.

R4 Any advocacy service, such as the CHC independence advocacy service, should be visible, located prominently and easily accessible and be clearly linked to the PTR process for personal assistance.

R5 An immediate action from this Review should be the development and communication of a simple description, in lay terms, of the PTR guidance. This should include, again in simple terms, an overview of the overall NHS Wales complaints system including the clarification of the roles of different agencies and organisations.

Getting help to access

R6 Patient support organisations, outside of the local NHS organisation, should consider the opportunity to co-locate support mechanisms for patients in agreement with Health Boards and Trusts. It is recommended that local discussions take place about how best appropriate visible accommodation (as free space) to organisations such as CHCs as an intention to make a difference to patient experience and concerns.

Improvements to complaints process

R7 In future every individual complaint should have a personal contact, either by phone call or face-to-face, to create a personal link to the complainant and to quickly clarify the key concerns and issues arising from the complaint. Depending on the nature and seriousness of the complaint, this should be undertaken either by the complaints team, lead officer or formal investigating officer.

R8 The Review has highlighted inconsistent delivery of the 30 days response target.

There is a need for both local and national attention to the current complaints responsiveness. It is recommended that the PTR response timescales be broken down into component parts to better support the achievement of responses within the 30 days timescale (and increasingly well within).

R9 Health Boards and Trusts should review, on an individual case basis, the opportunity to offer an early opportunity to meet and discuss a complaint and outcomes with complainants rather than rely only on a formal exchange of correspondence that may leave questions unanswered.

R10 In future the PTR process should ensure that patients are kept routinely and regularly updated on the progress and status of their complaint and the expected timescales for completion. There has been understanding within the review of complex complaints where more time may be needed, but this should be the exception rather than the norm.

R11 It is recommended that escalation systems should be implemented quickly, including a review of current outstanding complaints. A simple traffic light system would suffice to identify delays visibly and where senior or Board attention is needed.

Categorising complaints

R12 It is recommended that a clear system of classification of complaints be put in place from low enquiry through to serious complaints investigation. PTR should be fully developed into a highly professional complaints management system that responds according to correct classification to prevent misuse of the complaints handling mechanism. Not all issues are serious enough to become formal complaints but it is recommended that they still receive a professional and prompt response.

R13 There is a need for senior and executive leadership on the most serious complaints, in order to ensure that complaints are championed and receive the highest priority.

R14 Health Boards and Trusts should reassure themselves on the alignment of the AM (and elected representative) enquiry process alongside the PTR process. It is recommended that for completeness all complaints, irrespective of source, should be handled within the PTR process.

Infrastructure

R15 It is recommended that Health Boards and Trusts must quickly reassess the risk that is currently apparent of insufficient resource to manage demand in the handling of concerns and complaints and rectify this matter. The reallocation of resource in terms not only of funding but also skill set and knowledge should be immediately reconciled. In view of recent comments in terms of outstanding levels of complaints and incidents, as an immediate step all Boards should reassure themselves and the public of their planned intentions to bring this under control.

R16 It is recommended that adequate workforce needs to be located in each complaint handling team, drawing together the necessary knowledge and skill- set, such as, clinicians, doctors, legal advisors, call handlers and communication handlers, to expedite a professional and high quality level of complaint management. In depth training needs to be given to these teams in the correct handling of a complaint for the complainant. There is a level of seniority and expertise that should be expected in individual PTR teams and Boards

should assess whether they feel the PTR team is operating at the correct senior and responsive level.

R17 Good and proper formal investigation teams need to be trained up correctly to ensure quality investigation of complaints and incidents is carried out. Review of the investigation findings need to be policed into the workplace by senior executive staff and reported and noted at board meetings.

R18 Boards must ensure that teams in place deliver timely responses in line with PTR timescales for response and where possible improve on this in line with a continued drive for better patient-focused service.

R19 It is recommended that Health Board and Trusts should consider their current location and co-location of their respective complaints teams in order to bring together values, commitment and expertise as one team, whether this is achieved physically or virtually.

R20 Recognising the resource constraints to operate a 24/7 system, there should be some review of how active complaints support can be facilitated through 7 days and importantly into the evenings.

R21 There is a need to address variations that have developed in implementing PTR and with considerable different interpretation of the regulations. It is highly recommended that PTR must be restated to its original sound concept and deliver a more consistent experience across Wales.

ICT Infrastructure

R22 ICT infrastructure mainly represented through DATIX, for concerns, complaints and incident management needs to become the same national operational level in all Health Boards and Trusts. Specific technical details with DATIX, highlighted through this Review and commented upon by users, should be formally reviewed in order to improve the ongoing use of this core system. This includes testing its applicability to the primary care setting.

S23 In the future, there is a need to fully review the operational patient systems in place in Wales, ensure that new technologies for communicating with patients from one hub on a range of subject areas can be achieved. ICT has to be used as an enabler for change in supporting the general priorities and care objectives of NHS in Wales.

R24 Alongside other recommendations on access to better and more informed information in respect of complaints and concerns, it is recommended that in future information is held at an all-Wales level, is easily accessible and is used routinely in NHS Wales national discussions.

Courteous correspondence

R25 The NHS should improve the tone and content of its formal correspondence. There is a need to ensure that it is not naturally defensive and where an apology is needed, it should be made. They should properly reflect the sensitivity of the circumstances under review and acknowledge the difficult first step for any complainant of making the complaint formal in the first place. Best practice templates should be used to improve the tone and content of

complaints letters, whilst retaining an individual focus.

R26 A different approach needs to be implemented in respect of complaints correspondence at this important resolution stage. Formal complaints response should not be assumed to be the first step towards litigation they should be used properly to operate as the potentially last stage of complaints resolution when done effectively.

R27 Chief Executives should consider the leadership responsibility to personally oversee and sign off individual formal complaints on behalf of the organisation.

Regulation

R28 The role of HIW as the NHS Wales regulator should be defined and clarified in respect of its role in supporting the complaints system. This should be considered within the Welsh Government's response to the recent Health and Social Care Committee review of HIW's function and responsibilities.

R29 The regulatory arrangements in Wales need to be confirmed, clarified and clearly communicated. There seems to be scope for reviewing and aligning existing organisations' responsibilities and producing a much simpler landscape for those who wish to navigate complaints and concerns.

Redress process

R30 The redress system is a welcome addition within the PTR process, with a focus on finding ways of resolving complaints. It is firmly recommended that redress be positively retained within the PTR process.

R31 It is recommended that the number of levels within PTR is reviewed and reduced, based on professional advice, to consolidate the process and to achieve quicker access to independent opinion when a serious complaint is under review.

R32 Boards should ensure that redress does not become an alternative to good and effective complaints resolution at the earliest stage.

R33 In respect of redress, the NHS should determine whether it is best placed to deliver the redress legal advice and as a minimum whether it needs to formalise the level of legal expertise it has available. Health Boards and Trusts should assure themselves that the legal requirements of redress will be responded to, within stated timescales, within its local team and also the support provided nationally through shared services.

Addressing primary care

R34 There is a specific need to reinforce PTR in the primary care area, notably in respect of GPs where the bulk of NHS patient contact takes place. Valid concerns on its applicability and whether this should be refreshed for GPs specifically should now be taken forward. There is a specific need within the arena of primary care contractors to review the application of PTR. This should, as an all-Wales complaints system, be strongly contained within local contracts. It is recommended that a primary care based review be taken forward on the specific nature of complaints when overseen by contractors.

Investigation expertise

R35 Boards should ensure with immediacy at the time that this is appropriately judged to make sure that the right level of seniority is in place; in many cases senior clinical advice and expertise will be needed to allow for a resolution particularly in cases of poor care and treatment.

R36 In supporting recommendations about the development of expertise in investigations, NHS Wales should review the balance between developing experienced local investigation teams and as an alternative the potential for national expertise to be developed centrally, particularly to respond to the most serious and difficult complaints. This should be assessed by Boards locally but form part of a national discussion about better use of limited expertise and resources across NHS Wales.

CHC

R37 There is a need to specifically describe and reclarify the role of the CHCs in Wales in respect of complaints and concerns management. This should fit with an overall description of the complaints management system and the different roles and functions in place across NHS Wales to support patients.

R38 There is a need to increase the general awareness amongst the public and patients of the role of the CHC Independent Advocacy Service that is generally seen to offer good patient support mechanism, but there have been some reflections on limited knowledge of its availability. Working with Welsh Government and Health Boards and Trusts, there needs to be some proper assessment of CHCs in respect of their ability to give full individual support within their current infrastructure.

R39 The specific and ongoing role of CHCs in raising general patient complaints and community concerns, based on them acting as the eyes and ears of the local population, should also be restated and communicated in the context of the overall complaints and concerns system. CHCs should be supported to continue to have statutory functions alongside any specific complaints role in discharging their statutory role to act as the patient voice, assess the local quality and service environment and facilitate local discussions on service change.

R40 In view of this CHC Boards have to fully realise their balance of responsibility and in particular the necessary responsibility to search out and speak out about poor experience and practice of any sort in the care environment. There is a need to consider the training levels for CHC boards and members in particular in the discharge of the duties as eyes and ears for the NHS. It is recommended that the recent CHC review recommendations led by Professor Marcus Longley are therefore reinforced and fully implemented with pace and urgency.

R41 There has been a recent internal CHC review of the Independent Advocacy Service. It is recommended that these recommendations, which are now in the public domain, be fully implemented to further strengthen the deliberate role of the CHC in the complaints advocacy process.

2. Consider if there is sufficiently clear leadership, accountability and openness within the process

Themes identified by stakeholders and users

Increased visibility and awareness at all levels of patient contact

Visibility of complaints process and how to complain

180. General questions have been raised whether the NHS has made the complaints process, or how to have concerns addressed, sufficiently visible, so it is a simple and straightforward process rather than having to go searching whether to find the line manager response, member of clinical team or on a more formal basis the Chief Executive. This should be visible and apparent in all areas, reinforcing an open culture for concerns to be raised i.e. in the main entrance, in departments, in wards. The Health Boards running PALS services as physical locations in hospital sites reported the positive impact of addressing complaints early with an active team. There have been some suggestions that the CHC should be visible in such settings also and that this may help to demonstrate their role on behalf of patients and the public.

“They” and “Them”

181. However effective Boards have been in managing complaints discussions with users complainants have consistently given a view of feeling they are dealing with faceless organisations and managers who don't care. Contact through the review process has shown how organisations clearly care about the current process and want to improve. However, this criticism needs to be considered and worked through in terms of how to better manage relationships within the complaints process.

Developing an open culture

Culture needs to be addressed but cannot change overnight

182. The NHS provides excellent service to thousands of people every day and yet it is viewed as a secretive organisation in which it is difficult to tell the truth and speak out. Even extending an apology is considered an act of admitting liability for something or other and not as the basic act of contriteness that allows most forms of human activity to move on. Stakes are high but for the NHS to move on and be a valued service providing the best, it needs to get a grip on its top to bottom blame culture.

Openness and Transparency

183. The current system has been challenged through this review as, whether intended or not, there seems to be a default perception of a lack of openness within the complaints process. Better communication, a more sensitive approach and improved responsiveness would all help to alleviate the perceptions described.

Blame/No Blame cultures

184. Even where organisations are trying everything to openly manage issues, staff can still think they are working in a blame environment. Some of the external environment for the NHS does not improve this situation as there are constant stories of blame and retribution being promoted. A genuine system improvement comes from openness and this applies to both improvement to avoid complaints in the first place and to the manner in which we follow the complaint through once raised. It also becomes a leadership responsibility for the organisation to create the atmosphere and characteristics of a no blame culture. PTR can become a protective mechanism in such circumstances not least when areas of professional practice are under scrutiny.

Lack of accountability

185. There were some strong comments from stakeholders and complainants about wanting to see greater and sometimes final accountability in place around the complaints process and NHS in general.

A worry about the integrity of organisations

186. Not necessarily proven, but in the most difficult personal stories, real concerns have been expressed about complaints being turned against complainants and worries that future care will be affected. There is a harsh view that the complaints system is deliberately established to deny responsibility, to avoid an apology and even may go as far as to conceal evidence. The latter point has been made at least as a perception from some complainants.

Legal duty of candour

A duty of candour

187. There have been strong calls through the review process for a legal duty of candour, as reflected within the Francis Inquiry, in order to secure and ensure a proper open response from those involved in complaints.

Staff raising concerns

Disconnect between top and bottom of organisations – the importance of relationship with staff

188. Although this may relate to the complaints process, it is really a reflection that change happens best when informed and led by staff through and across

structures. The best organisations are those that allow the creation of innovative improvements to services and show they listen to staff on both concerns and ideas.

Staff worried about raising concerns

189. A number of stakeholders, notably around staff organisations, reported that there are examples of staff feeling unable to speak out on local concerns, particularly those that relate to quality and safety concerns. It is important to create an open environment for concerns; this starts with leadership at the top of organisations, but the size of the NHS organisations in Wales requires this to be reinforced right down and through structures. There are examples of clinical staff feeling the need to meet in confidence to share concerns; in the best examples, there are uses of open and transparent reporting approaches being established by organisations. Although whistle-blowing policies are in place to support the most extreme of cases, this still actually tends to be a difficult experience for all involved. It is quite apparent that the organisations need to work very hard to give confidence to staff on this issue and on getting staff to speak out about concerns in the workplace.

Acknowledging and responding to low morale

190. There is a range of reasons that may be influencing a sense of low morale. These are clearly difficult times for all public services and the NHS of course is not immune from this. However, a more rounded assessment would also point to the environment in which staff members are working: indicators such as higher sickness and absence or difficulties in recruitment. Focus is on patient satisfaction and rightly so, but part of understanding how we can improve systems, process and outcomes (relevant to the field of complaints) relies on an understanding of staff satisfaction. What should be focussed on is that committed, enthused and empowered staff will positively influence their immediate environment and in the NHS example ultimately to the care provided.

Staff survey

191. However well staff engagement may be considered at a local level, the NHS is achieving lower levels of staff satisfaction than it would wish. Active use of staff surveys or staff temperature checks inform an organisation of the way in which it can better listen to and work with its staff. It is to be welcomed that regular staff surveys are undertaken; but they are a real opportunity to work with staff and teams to show what is important to the organisation and the measures being put in place to respond to staff concerns. An organisation that is responsive to staff concerns will instil an environment of responding to concerns of those who we care within our services. Where staff morale is low, active responses to such concerns can help to evidence an organisation that is pausing and listening.

The importance of listening to professional bodies

192. Alongside formal complaints, staff concerns and poor patient experience can often be shared confidentially with professional bodies that have a role to support staff in the NHS. The better organisations have openness in being prepared to listen to concerns and to be seen to act quickly as concerns are raised.

Commissioning responsibilities

Recognising Health Boards' roles in commissioning services for their population

193. Often complaints processes focus on the specific role of the hospital or service that has provided assessment or treatment. However, Health Boards specifically have a role to commission services from other areas for their population and also have a responsibility in commissioning to be involved in quality and complaints issues for their residents.

Board duties and profile

There always needs to be strong leadership from the top

194. The best complaints handling teams and those seeking to improve most, seem to be able to describe the Chief Executive as an active person within the complaints handling team, usually with support available from senior clinical staff. Senior executives are not just there to oversee the data; they need to be a daily part of the complaint resolution process.

Are Boards properly reviewing and scrutinising problems, concerns and complaints

195. There is a leadership and governance role for Boards to play to act on behalf of patients and communities and be impatient for action in this area. One test for complaints is the level of confidence from individual Boards' annual quality statements. As Boards produce structured assessments and review themselves against healthcare standards, there is a need to review and challenge Board capability.

The public want to see some level of comparison

196. There is a general comment about wanting to see good performance data in respect of complaints and learning across Wales. Some general observations have been made about wanting to make more sense of data and comparison eg on patient safety and outcomes across the NHS more generally.

Stepping up national performance management in respect of complaints

197. Is there a constant message emphasising the importance of concerns and complaints management at the highest level? As far as NHS process is concerned, do concerns and complaints feature as the highest priority for targets; if not they should. Similarly does Welsh Governments review meetings with

Health Boards and Trust teams include patient experience, complaints and PTR issues. Do the Health Board and Trust Chairman reviews also focus on this critical area. Complainants, and the public more broadly, want to see this featuring at the top of Board's agenda as a key indicator of patient experience, problem areas and the responsiveness of the organisation.

Lack of clear reporting and public information

198. It is perceived that some organisations are not reporting concerns, incidents and problems with services as openly as the public or stakeholders would wish. This means that trust can be affected and a commitment to openness and transparency must be visible and reinforced through Board papers and external communication. There is a specific need to better evidence progress and improvement in the complaints context. There is also a need to acknowledge areas for improvement and to not avoid presenting areas that require a focus.

Organisational stability

199. Some comments have been received in respect of the negative impact that significant personnel changes at the highest level of the organisation can have across the structures. This fits with the knowledge that leadership in respect of complaints is a key contributor to the ability of organisations to successfully handle and respond to complaints.

My reflections

200. This means that having an effective complaints process in place is a challenge for leadership at all levels. This means specifically Chief Executives and Boards, but also includes those responsible for care and treatment right down through the structures not least at the level of clinical teams.

201. The Chair, Chief Executive and Directors are responsible for the daily and lawful operation of the organisation. It takes many years of practice and experience to become fit to hold a position at this high level. I would expect such individuals to lead by example and their own values and priorities are critical in establishing the environment for a high-performing and responsive organisation. Only one group of people have more power than the board and that is the users that they have to stand shoulder to shoulder with, look in the eye, report too and humbly serve.

202. There are some immediate opportunities to make improvements. Simply taking full responsibility for the management of the complaints process would be a start. I always ensured I was overseeing and managing the most serious complaints myself and not simply leaving this to junior staff. The approach should be to constantly listen to patients and staff and to physically lead and drive the necessary change to support the process; as in the end this is the customer/patient relationship that is at stake. There is a need to set up routine

analysis to remove poor service levels and for staff members to take a personal zero tolerance approach to creating incidents and complaints.

203. What an opportunity is being missed in this case when even the worst complaints should be accepted as a gift that is full of information from which you can learn how to improve yourself or your organisation. Understanding the contents of a complaint and changing what has caused it is the quickest and easiest way to avoid receiving another one. When you receive a complaint it is best to take it straight on the chin and rectify it. Taking ownership of the complaint is always better than denying it or trying to pass the blame further up or down the line. Those who have taken the time to complain will appreciate your goodwill and help with their complaint; ultimately, they will be pleased to see that their poor experience will not be repeated with others.
204. It is the basic job for every chair and executive to reason why their organisation is being complained about and why their patients or customers have had reason to speak out about their discontent with their services. At the complaint level their leadership is required to evoke change to prevent the complaint repeating itself and to support their teams with change so that they do not have to receive a similar complaint. Organisations that have executive management that do not believe they should handle complaints themselves, to simply find out what their customers think, will not be successful for long!
205. Complacency has been the cause of the downfall of many organisations both large and small. This can also apply even to great institutions like the NHS that may simply believe they will just last forever. It is therefore very important to prevent lethargy creeping into all areas by ensuring that your investigating bodies are not connected to you in any way. It should be that they are sufficiently independent and empowered to regulate your behaviour and order investigation and change if you are slowly moving unknowingly down the wrong path. Active assurance, locally and nationally, is required.
206. In terms of this culture in the NHS the systems are hailed as the correct way by those at the top but are letting those down where it counts in implementation. Not receiving complaints, ideas and suggestions from your members of staff usually means that there is a blame culture at hand or a team afraid to speak out. Systematic top down management systems cause this as you must do as instructed by your boss. These systems usually let your staff down and do not offer the opportunity to innovate based on their daily experiences and ability pass the message up. It can be quite demoralising when this is in place in the workplace and in the end leads to silence! It is important to always be listening.
207. There is a need for strong leadership and authority, but there can be extreme cases where this can create an environment of fear and bullying. I am not saying I have seen this in action, but I have heard concerns expressed about it. This can

easily be addressed by having faith in leadership that leads by example and creates an honest environment. In my personal experience this is one of the most important examples of people development and it starts in the Boardrooms. Staff members watch those in charge of them all of the time; the practice they see reinforces their own practice. So a simply message from me is that if you want to treat your patients with respect then develop and lead your teams from the front and treat them with respect. To reassure you, I have seen positive and effective leadership during the Review.

208. Organisations should always be asking themselves “Why did we do that?” Having a policy of being open is necessary to reduce complaints and staff should be trained correctly to follow it. Is this better than a rule of candour? Does candour frighten staff into silence? Telling the truth or not at the place of incident by the people involved is what makes a complaint happen or not. I have been trying to establish whether there is any proper training for staff that carry out root cause analysis investigations especially in the area of dealing with family or carers? On a specific issue is training available for those staff members to prepare properly for redress?
209. My strong advice to any organisation is to routinely listen to what staff members and users are saying. They must be encouraged and supported to openly speak out about all concerns. This is a brave step to take but reflects an open and ambitious organisation and I have received a number of comments highlighting that there are staff that believe it is difficult to raise concerns. This must be supported and I have heard leaders at the highest levels commit to this principle. Staff must also let you know the difficulties they experience with the processes they are trying to use and it is the duty of the top team to ensure their issues are resolved. If this is not done promptly or in the appropriate manner, then it can also lead to blame; at this point experience says that any hope of satisfactorily concluding a concern or complaint will disappear.
210. Therefore, as a further step on, it is quite reasonable to believe that some patients are also afraid to complain when incidents occur during their treatment if they also believe that no one is listening or that care may be taken away from them during their stay.
211. This situation is of course not going to improve unless there is very strong will to stop delivering bad quality services with bad manners which are the cause of the complaints circle in any industry. I have seen a commitment to act and improve. NHS Wales must decide what represents the ideal complaints system for staff and patients; and what develops the environment in which this can thrive so that the complaint can be recognised as a step towards better service rather than an attack on others.

212. Top management testing their systems continually every day is a step towards this. If you are a manufacturer selling your products through a set of retail chains you would regularly visit the stores to check that your products were effectively displayed but you would also send in phantom customers to see what that retailer's customer journey for your products was like. This could be used to test out the patient journey as well. Use your own complaints boxes, phone your own help lines, use your own web sites, always monitoring atmosphere and quality yourself, setting up steam valves for staff to speak about their concerns. Ultimately, you need to establish a process whereby you put yourselves in your patients' and staff member's shoes.
213. Consider who is really the boss, who is really paying the organisation, who should the team serve, who should everyone look up too, who should all please and put themselves out for. The Customer! The patient! There can be some confusion about who is ultimately in charge, whether managers, politicians, doctors, but in my experience where there is potential confusion, or at least different tensions, it is better to focus fully on the real bosses i.e. the customers, and for the NHS, the patients. In ensuring their journey through the NHS is undertaken in a professional manner, with courtesy, respect and compassion you will have served your real bosses well.
214. Companies are also very speedy and agile when it comes to sharing good practice and eliminating bad practice. Their flatter management structures and more borderless divisions can change surprisingly quickly when needed and again this is about competitive edge to win and keep your customer base intact. There needs to be a more business-like mandate going on at board level, which in my view should draw in the patient and complaints experience very visibly and with appropriate measures. It should be defined how all quality management should work and deviation from this should only be allowed when discussed and found to provide better levels of excellence. It then becomes easier to judge a Board in respect of its priority to and performance around concerns and complaints – and this can be extended to other areas of performance delivery also.
215. Complaints may be handled more appropriately when empowering leadership in the correct places. Most complaints are about concerns around the patient and how they are treated during their hospital experience, although complaints will also be received in respect of community services, mental health and primary care. In the future, care is likely to shift to a more community-based environment and this will affect the nature of complaints. Therefore all places will have to have adequately empowered leadership if they are to function effectively at a basic and organised level. A hotel lobby has a head porter, the military has its warrant officers, industry and business has its general managers. The common characteristic is that they are all experienced and well - trained individuals who

may be relied upon to run their part of a larger team and ensure it's successful over all functionality.

216. As an example, ward managers fall into this category. Their leadership is imperative to good quality ward practice. Planning daily routines for patient management, training their teams to high levels, ensuring discipline is maintained throughout the ward portfolio of activities, ensuring everyone knows how to carry out their duties and most importantly ensuring the fundamentals of good nursing care are given in a compassionate manner to the patients under their supervision. It can feel as though ward sisters have been disempowered. Has their job role been changed and taken them away from the ever watchful positioning that is needed to ensure even the most basic of courtesies for the patient such as noise reduction, resting times to recover, leading ward rounds, consulting with families and being there for when we need them to ensure that the standard of good care is not only offered but delivered to those who need it. If the ward sister is truly empowered to do these things I believe that many concerns and minor complaints could be managed out at source at the bedside. So NHS organisations need to look at the extent to which they trust, empower and train the basic building blocks of their team across the organisation. I have given the example of a ward sister but could as easily be speaking about a consultant leading their immediate clinical team, or a supervisor leading a group of administrative staff.

217. Conveying these responsibilities would set the example to younger or new staff joining the organisation, cemented by values and leadership by example. It would surely improve the people to people management concept that can disappear over time especially with more systematic approaches.

218. In terms of priority afforded to complaints, there are some simple questions I have posed to assess the extent to which Chief Executives and Boards are fully discharging their responsibility in this area. Do Chief Executives personally sign off complaints or is it delegated? What evidence is being compiled for the board and Chief Executive to be able to review the complaints and incidents status regularly? Are Boards and Chief Executives interested and pushing to obtain this management data on a weekly basis? Is there evidence of the gathering of complaints and incidents from the frontline? My own experience of customer complaints was to ensure that together with my team I reviewed them with due time and attention on a daily and weekly basis to allow incident, concerns and complaints themes to be understood. This led to further serious management action and often a personal response to ensure that the organisation understood the seriousness of this, whilst also embracing the learning it provided.

219. Effective leadership requires a number of factors to come together: communication; ownership; empowerment; and accountability. Authority and responsibility should always be together in the same place. I have come across

some difficulties in achieving this in the NHS in respect of the complaints process; when this is not clear and in place it can lead to an environment of passing the buck and a lack of responsibility. This needs to be sorted out with strong and intentional management leadership in all areas of the operations.

220. I have heard examples of where members of staff in NHS Wales do not feel they can speak out, but given the Francis Inquiry this is probably more generic to the NHS rather than peculiar to NHS Wales. Large and complex organisations can create environments that can feel distant and disconnected from staff depending on the structures that are put in place and how effective communication is from the very top of and through the organisation levels.

221. In my experience there are three factors that impact on why people may feel they cannot speak out in an organisation. They are fright, fear and foolishness. These three factors must be taken away to open up the way for responsibility, empowerment and accountability to thrive and drive the organisation; to bring out the best in people by telling the truth without reprisal. There should be measures that measure staff and patient morale as well as budget and efficiency KPIs.

222. It is not the responsibility of those staff lowest down the hierarchy in the organisation to bear the brunt of the user's anger or to be the person who has to convey good or bad news. It is certainly not their responsibility to be the place where the buck stops. This requires support down and through the structures. Every employee should be the guardian of truth and honesty in any organisation and they should be championed for speaking out loudly against bad practice and not be vilified. In doing so the organisation can use the strength and power of its people to ensure that their customers get only the very best. There will be those who think that this type of vision is a pipe dream or that it will never work like that – unfortunately you do not need negative people in the organisation as they will affect positive culture and change. The issue is how you progressively change negativity and concerns into a positive response to develop people and to be driven by staff support.

223. It is important to focus on the complete experience end to end; this means judging progress through the whole of the patient journey. There is no point in excellence at one point, but inadequate care at another. The patient will remember the poor experience, irrespective of the other aspects of good treatment. The patient's journey could start with his GP, move through social services, admission to hospital, receiving treatment and returning home. From the patient perspective, this can often feel like a long journey, even if it is just a passing contact for staff; in many cases, patients are having new experiences out of their normal comfort zone and in an alien environment removed from their normal day to day lives. No matter how long this journey, staff at all levels must realise that the most important distance of space for the patient is, for example,

during a hospital stay the 1 metre around their bed. It becomes their world and it can be a happy or lonely place depending on conditions. It is the vital one metre.

224. When you are in this space it is also important for staff to make themselves available to the patient and to do so on an active, not just reactive basis. Common courtesy is the start, just a simple greeting or an acknowledgement to them in the manner they have chosen to be addressed. This includes making eye contact and through this offering a friendly and open face that they know they can communicate with. Best practice in customer service is to continually be asking open or closed ended questions that encourage response. Sentences that begin with How, Have, What, Where, When. It reflects an interest in the individual and not just a task or function to be completed. This is most easily conveyed when asking oneself how we would wish to be dealt with if we were in the shoes of the patient. It is about interacting with the patient, in a sensitive manner depending on their condition and not just anonymously entering details or completing records. During this review and on other personal occasions I have seen both ends of this scale when visiting patients.
225. This type of communication skill needs to be trained into the staff at all levels. Together with a watchful eye and a core value of compassion they are good tools of the trade for those who enter the vital metre of space around the patient.
226. In terms of creating the right culture for avoidance of and management of complaints, I need to comment on some of the professional attitudes that have been reflected to me. I see clinical staff as critical to creating the environment for concerns to be raised positively. However any NHS organisation is structured, the main contact points are going to be with clinical teams and professional staff. However, I have heard from a range of stakeholders that clinical staff and doctors can be hesitant to get involved early on in complaints processes. When formal complaints have been received they sometimes have to be actively pursued to provide information to support an investigation. I have however welcomed the clarity I have received from the relevant professional bodies who advocated the full involvement of clinicians. Even to the extent that they called for consultants to be acknowledged as responsible when they are acting on behalf of the clinical team for whom they are leading.
227. Attitude is conveyed from the top. Stakeholder and complainants reported that remote mannerisms of high-level medical, clinical or executive staff prevented easy discussion of complaints based issues. This may be perception rather than reality, but remains a significant issue. The top team have to remember to be courteous to junior team members and patients at all times and realise that it is their position to break down these communication barriers. Top management people in any industry that cannot keep their feet on the ground and their ego under control not only de-mean themselves but also the organisations and teams that they fail to lead to be successful. Kindness, understanding and patience are

required especially when developing younger team members and especially when communicating with patients, their families and carers.

228. The environment we create for patients also reflects the importance that we are placing upon them. I am a firm believer of the need to positively receive the user into the organisations services and facilities. As a general comment, many complaints I have reviewed within the terms of reference for this review start occurring from an inadequate first contact, communication point or difficulty in accessing services. For example, I have seen examples where the standard of comfort in patient waiting rooms is not good or patients are left waiting on inadequate bedding and without provision for long periods. The NHS needs to welcome patients positively into its services, focusing as far as possible on conveying an individual focus and experience, whilst noting the significant volume of care and treatment that is provided and especially in the area of A and E.

229. I have heard time and time again in my contact with stakeholders that “you can’t just tell people what to do, this is the NHS!” “It is a unique organisation!” However, my contact with those leading organisations shows me that there is a real willingness to change and to create a more responsive service. It just needs a change of spirit to ensure everyone acts in support of this from the top and right down through and across the structures. I would advocate using the review of individual complaints and complaints themes routinely, but always with a focus on actions, as supporting this culture that is needed to put in place for strong and proper customer care.

230. Perhaps I need to explain the difference in corporate culture that I have experienced in my own career. The zero tolerance of quality defect in industry is a good example of what the NHS needs to get to in providing health services to the general public. On entering an NHS hospital for treatment I would be expecting the highest standards of professional treatment, care and compassion as well as leaving it without anything conditions I didn’t come in with. The learning system needing to be adopted and reinforced in quality circles in NHS Wales, is for example including the development of a no blame system that learns from the incident investigation approach. Another example could be that of the aviation industries constant investigation of air-worthiness. This would be welcomed and a great confidence booster to NHS users. Create this no blame approach for the NHS in Wales as staff and organisations need to be able to openly and properly report incidents.

My recommendations

Increased visibility and awareness at all levels of patient contact

R42 It is recommended that the visibility of the PTR scheme be radically increased in all areas of patient and public domain using different ways of contacting by using traditional approaches and new technology. This means ensuring that the patients, families, carers and

members of the public have ample opportunity to connect with the PTR scheme visually at all times and that this is openly displayed in all departments, access points and reception areas. Images should be simple and consistent in every such space. PTR concern, complaint, suggestion boxes should be made available in wards, family rooms and reception areas and correctly monitored by the ward Sister, departmental head and executive staff.

R43 All individual patients, their families and carers should be introduced to the PTR scheme by the lead individual for the area (eg Ward Sister) as part of their check in processes, for both emergency (when suitable) and planned admissions. For those patients who are not supported by family or carers or have seeing, hearing or other such impediments it must be ensured that they are personally introduced to the PTR scheme by a suitable member of staff.

R44 All members of staff should be quite familiar with the Putting Things Right scheme and be able to support, comment or signpost any concern to the right individual

R45 PTR needs to be a branded process within the NHS operation; this means not simply acting as guidance, but stimulating routine contact with patients and users.

R46 PTR should be openly available, discussed and included in correspondence when contacting patients. For example: *“Putting Things Right is here to help you; if you have any concerns during your experience with us, please ask a member of staff or request further details of PTR.”*

Developing an open culture

R47 It should be clear for users of the NHS that its employees should be responsible for and accountable for their actions. This should be in accordance with employment law, the rules and regulations of the organisation to which they belong and to the NHS.

R48 We all have a responsibility to create the NHS we want. Calls for a no blame culture and a learning system are more than words. It is recommended that NHS leaders create the right open environment for their respective organisations. It is also recommended that a no blame culture but constructive debate be re-requested outside the NHS environment and be adequately moderated allowing this to openly involve stakeholders, patients, users and politicians. Improvement through deep quality investigation and debate is better.

Legal duty of candour

R49 Large organisations have a duty to compel honesty in their rules and structure. Post Francis, the rule of lawful candour should be formally placed on the NHS in Wales, consistent with approaches in other NHS systems, as a clear statement of expectation. The legal duty of candour should not rest only on the shoulders of individual employees, but should be reflected on the employing organisation as a clear corporate responsibility and tone for the organisation.

R50 It is recommended that assurance is given by Boards that also reassures the public that issues such as discrepancies in record-keeping will not be tolerated and will be formally investigated and addressed should these occur.

Staff raising concerns

R51 It is recognised that Raising Concerns policies are in place within NHS Wales, supported by specific whistle-blowing policies, the latter to respond to the most extreme and difficult of circumstances. Health Boards and Trusts must ensure that they create the right environment and clear guidance for staff to be able to openly report concerns without consequences to themselves. Boards must specifically reassure themselves that staff can and if they choose to do so. There must be clear and appropriate provision, in the most serious of cases, for whistle blowing and speaking out about concerns and issues.

R52 The Raising Concerns process should be regularly reviewed locally between respective organisations and staff side organisations. At a national level, this should be subject to review between NHS Wales collectively and national staff side representatives and organisations to ensure it is fit for purpose.

R53 Health Boards and Trusts should have in place a mechanism to highlight staff concerns emerging through other sources, including staff organisations, representative bodies and Assembly Members. This should be reinforced regularly at the all-Wales level as a conduit to allowing staff concerns to be openly and confidentially expressed.

Commissioning responsibilities

R54 In order to increase discussion and profile on complaints, Health Boards need to also discharge their commissioner responsibility in funding services in other Health Board and cross-border areas. This should also recognise and include their responsibilities for primary care and the contracts in place for GPs, dentists and other primary care contractors.

Board duties and profile

R55 It is recommended that there should be more visible reporting of complaints themes, actions and responsiveness at Board level. In support of a more open culture, Boards should use the opportunity of their public Board meetings to allow difficulties in services to be identified, alongside their positive response and actions to put this right.

R56 It is recommended that complaints should be highlighted within the Tier 1 Welsh Government targets and be a focus within performance reporting arrangements to Welsh Government. It is recommended that a more consistent template be put in place for common reporting of complaints and production of Annual Concerns Reports across NHS Wales.

R57 It is recommended that the complaints team needs to be elevated within each organisation and should be clearly linked to the corporate reputation of the organisation. Specifically, there should be a clear champion for complaints concern at the Board and executive level.

R58 It is strongly recommended that Health Boards should immediately review their PTR risk levels to ensure that they have fully resourced the requirement within their current budgetary means.

3. Identify how the NHS in Wales can learn from other service industries; Consider the wider cultural 'patient' service ethos and how staff are supported to deal with patient feedback

Themes from stakeholders and users

Putting the patient first

A stronger patient perspective

231. There have been a number of difficult sessions observed involving patients in complaints, but working through the concerns and experiences they have outlined, the reasonable call is for the process to have a much more patient-focused feel for process and outcome. This means maintaining high sensitivity, active communication and development of open relations. The outcome of the patient has to be put first if a customer-first NHS is to come about. There have been some strong suggestions about whether citizen or patients' panels can play some role in overseeing complaints and changes to be made.

Receiving patients into our services

232. Complaints can often start with the first contact. It is really important to start at the very outset of the patient's experience to get this right. There is a need to create an environment to positively welcome and receive patients into NHS facilities and services. The more we focus on this holistic experience and all contacts means that we create an inviting and open environment for patients. This is an attitudinal and culture change visible in the best proponents of customer care. This is not always about carrying out core duties, but showing the little extras and adopting an overall professional approach. This would include the initial correspondence that patients receive as setting the early tone.

Co-producing the complaints process and outcomes

233. If we want to be owners of the NHS as taxpayers then we also have to be prepared to be involved in its outcomes. There is an argument for the regulatory system to involve the public and patients in influencing how complaints are handled. Therefore we should have more involvement by citizen's panels in the adjudication and review of complaints. This could have the potential to form part of the CHC function to retain some independence, or could simply be the positive development of external relations by the Health Board or Trust. There should be provision to be able to voice public happiness and dissatisfaction in equal terms and how it should be managed for those people more independently. In business, when let down, customers can simply choose to walk away and never buy again. The same choices do not apply to the NHS; as this cannot be the case with the services supplied by the NHS more involvement of independent regulators and citizens' panels should be seriously considered.

Involving complainants

234. Beyond the immediate complaint of those wanting to raise concerns about services, there is a richness of experience, which will be both positive and negative, that can be brought into the way organisations look to improve their services. Is there any opportunity to draw in complainants regularly into reviews of process or complaints themes for them to be able to inform and influence local changes and practice but in a group setting or a complainant's panel? This would potentially also provide an opportunity for them to communicate the active approach of organisations to involve complainants; this could be quite a challenging process but would allow a real bridge between those with intentions to make change happen through the complaints process and the organisation

Instilling care and empathy in our staff

235. There is a real perception that staff members have become distant from their core purpose of providing good quality care and with compassion; this is stated as a comment/ perception rather than as fact. It is also true that the NHS is operating in a very busy environment with high public expectations for services. NHS Wales needs to demonstrate an approach to training that reinforces the basics of care, a foundation for customer care and quality approaches and reinforce this through the way it acts and behaves. As a minimum a poor experience in the complaints process does significant damage to organisational reputation for caring.

Clarifying core values may help to raise the game of the system

236. The NHS operates on the premise of having staff focused on care and treatment for individuals in vulnerable circumstances. However, there may be some merit in reconfirming the core values for what the NHS is about as a way of re-gathering staff and the public about what they are here for. These values should fit with high quality patient experience, quality clinical interventions, done safely, done without harm, providing the correct treatment with dignity, respect, passion and kindness.

Compassion and dignity are important words

237. It is not just about delivering exemplary treatment and doing so technically well; the NHS is based on delivering this with care, compassion and dignity. The more we reinforce this as a day to day focus at all levels and for all staff, the more we get closer to delivering individual care and experience. Many complaints relate to a lack of care, compassion and dignity.

Knock-on effects of a complaint

238. The NHS needs to better recognise the knock-on effects of a poor experience and what it means for patients and family members who will continue to need to access local services. This is an anxiety that doesn't disappear, but can be

supported through a positive complaints experience. The NHS is a service that people need to inherently trust and therefore confidence can be knocked.

Aligning targets to outcomes

239. The system prioritizes the targets that are set and much of the complaints process then relates to process rather than outcomes. It should be remembered that in industry it is outcomes that matter. Unrealistic targets do not improve quality and it certainly does not focus you on the customer's requirements and in the case of the NHS the patient. The only way to judge actions, results and strategies is by their outcomes.

Training: complaints and customer care

There is a big training job to be done

240. Training is critical to handle the underlying culture and a feeling that things have always been done in the same way. It should be acknowledged that staff will be managing very difficult scenarios and they need to be trained to act professionally, with humility, but with clear expertise in handling complaints responses regularly. Experience creates confidence; but it is the manner of handling complaints that needs to be focused on.

Adopting a customer care approach

241. It is a huge task to change the NHS culture to a one team, customer first ethos, although this should not be controversial to a set of services and staff who come to work to provide good care and treatment. Over time, and this reflects a longer term aim, such an approach on putting the patient first should reduce incidents and complaints by becoming patient centric and in turn reduce the formal complaints and redress compensation.

Training clinical staff to communicate bad news

242. Although there has been some focus on expertise for complaints handling, a reflection on the themes that lead to complaints has highlighted some difficulties with communication with families in the most difficult of clinical circumstances. This needs to be performed sensitively but raises needs for targeted training, mainly for clinical teams, in respect of deteriorating patients and end of life care. This also requires close team working about what has been shared so that the ongoing patient needs can be managed by the relevant service, for example, if this requires ongoing ward-based care.

Making the system fair and independent for complainants

Demonstrating independence through the complaints process

243. A number of comments have set a challenge as to how the complaints process can operate more independently of the local NHS organisation. At the moment it can feel like organisations are reviewing themselves as to whether

there has been a breach, liability or failure in complaints terms. As a minimum, there is a feeling that teams should not be reviewing themselves in a complaint response for their own area and there should be some internal independence; increasingly there is a call for investigations to be led outside the organisation with some expertise; finally there have been observations of wanting to know what independent agency or individual is available for complaints that require full independence. There is a particular concern that the NHS is deciding everything to do with redress, when it may not have the requisite experience to discharge this properly. Some commentators reflected that the previous independent complaints review process had at least provided this external challenge in cases where this was necessary.

Communication

More effective communication

244. Many difficulties with complaints arise from poor communication through the course of care or treatment. These are often made worse through poor communications subsequently through the complaints process. 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.

Core communication skills for clinical staff

245. Clinicians, and doctors in particular, need more training in the handling of people; they need role-play training for communication in the same way as other organisations. People to people skills can appear low down the list in the NHS training programme. Proper levels of such training should be put in place for internal staff relationships as well as those that need to be improved for the patients. Communication coaching is a skill set especially for those who need to deal with the communication of bad news. However, it is more than this - even on an everyday basis there are those who need to be coached in the commonality of passing the time of day in a pleasant and polite manner.

Patient journey

Care coordination

246. It was quite clear from comments received that complaints can arise during the moments of handover from different parts of the system, whether in hospital, on discharge from hospital, out to community or social care services or oversight by GPs. An underlying theme therefore to avoid the development of complaints is to concentrate on care coordination and these handover points; this means actively planning with patients and ensuring they are properly passed to other services, clinical teams and agencies. This seems to be a particular feature for older or frail people.

Care for children

247. Children and younger people need special attention through the complaints process. Children do not tend to complain in the traditional manner of adults using any formal processes that are put into place or by utilising materials that most adults would search out to use as the tools of complaint. It is important to understand the work done in this area to be able to provide the correct and different environment to help children and younger people make their views known. Considerable work and study has been conducted in this area and is available. Provision of facilities and practices for young people to speak out about their circumstances varies throughout Health Boards across Wales considerably. Advice should be continually sought in this area from the Children's Commissioner for Wales.

Effective team-working

248. The NHS has a wide variety of staff in place in both clinical and non-clinical functions, all focused on providing services to local populations and patients. There was some acknowledgement of the way in which boundaries between professional staff groups, whether doctors, nurses, therapists, etc can cause some of the system difficulties that lead to complaints arising. Also it can cause some difficulty in reconciling the reasons for a complaint when comprehensive responses are being put together as clinical teams may not agree with each other. Clinical teams, the way they work together, is critical to finding solutions to avoiding future complaints. Doctors' representatives had a strong view that where consultants are the head of the team providing care, they should accept and be recognised as having the responsibility for complaints.

Celebrating positive experiences

More compliments are being received

249. Generally organisations commented that alongside some very difficult complaints and an acknowledgement that numbers of complaints had increased since the introduction of PTR, they had also conversely seen an increase in compliments particularly noticeable after the Francis Inquiry. Without exception compliments were acknowledged to significantly improve morale across staff and services.

Public satisfaction

250. It is true to say that NHS Wales even in difficult circumstances and profile continues to achieve high satisfaction ratings for the NHS services provided in NHS Wales, and with some evidence of higher levels of satisfaction on some issues in comparison with other home countries. We should pause and acknowledge this; but an ambitious organisation should also recognise that even with the highest satisfaction ratings this can mean high numbers of individuals with concerns or cause to complain. In the commercial world, this information is

used to continually improve and refocus services to minimise those who report not being satisfied.

Staffing for compassion

Variation and workflow

251. It is common in industry to make work flow charts that allow the systematic part of the business function to be carried out in a manner that enhances the quality of the work. This does mean however that you also find out what level of skill set and how many hands you need on the job. Asking people to work in the wrong ratios can cause poor quality, incidents and risk so this is a seriously studied matter in industry. Getting the management and infrastructure of quality workflow in place is vital to the next level of customer care management. If the workflow is well managed the work force will provide better quality results and will be happy to be accountable for their work and to suggest ways to improve outcomes. As a result the whole process becomes a higher quality procedure. This also saves money.

Changing culture

252. There is a way of doing things that seems to be vested in tradition and systems that have been built up over many years. It is not possible to simply resolve the complaints system by focusing on rules and regulations. The key to improvement, and changing the way things are done and making this sustainable, is to focus on the development of staff and this includes sharing with them the priorities important to the organisation, but critically, those that are important to the patient like courtesy, dignity and basic customer care.

Staff who don't adhere to values for care

253. It is not good business to keep employing members of staff whom do not perform properly. They damage the greater organisation. In the environment of the business world poor performance or lack of adherence to organisational priorities will be addressed. Bad practice should be taken away whatever it is or whosoever is doing it otherwise it can just brings the organisation tumbling down. Tackling poor performance is also the only way forward for those who have to pick the organisation up again and move it forward. If employees are unsafe they should be removed or retrained correctly. This has to be done to protect the user, or in the NHS case, patients. Patients always have to be put at the centre of focus if you want a customer centric and quality organisation.

Adopting a zero tolerance approach to lower level errors

254. There should be zero tolerance of minor dysfunction to reduce the incident of complaints levels. It is not so much about saying sorry but at this level putting into place proper fault control levels to prevent bad practice before it happens and prevent the mistake in the first place.

Compassion fatigue

255. In the main members of staff in the NHS do genuinely come into work to do a good job and to provide quality care and treatment. However, the environment they are working in can create a compassion fatigue and suppress perhaps normal instincts for care. In tough work circumstances you try so hard that you do get compassion fatigue. This can be especially in high-tension nursing or clinical settings, or where extended shifts are a routine through to crowded reception areas or busy call handling teams. This has the potential to impact on normal high standards. There is also a tension that the increasing number of tasks and paperwork required to move patients through the care system is diverting nursing attention, which should remain supportive of getting the basics lined up. This should not detract from the reality that there are thousands of expert nurses and members of staff well engaged with patients and their families on a daily basis. There are also peak moments of pressure that are predictable each week in terms of the pattern of services and demand that can create fatigue if not adequately staffed up.

Impact of complaints on staff

256. No complaint is going to represent an easy process for members of staff whom participate in the review and investigation of concerns. These can be emotional events for both families complaining and the staff who are the subject of the complaint or who have had an involvement. In the most difficult of cases, as well as focus on more active support for families, organisations need to put in place support if needed for those who are the subject of the complainant.

Responding to staff attitude

257. With respect to complaints about attitudes of staff the process does not seem able to address such concerns appropriately. Responses tend to refer to a lack of written evidence in health records. Complainants are frustrated as it is unlikely that members of staff would record inappropriate incidents of inappropriate attitude. Likewise in cases where personal care, dignity and respect issues are highlighted as a concern, the fact that the health records are silent with respect to these issues is often taken as evidence that the incidents did not occur. It would be helpful for senior staff to meet such complainants to explain the limitations of investigations but provide assurance that incidences such as this are noted and will in the end result in managerial action.

Working under duress

Media stories and reports

258. The NHS has been in a difficult environment notably since the Francis Inquiry, but the NHS will always attract attention and there is a particular closeness of the

relationship between the Welsh public and NHS in Wales. However, higher media reporting can have a connection with both higher levels of complaints and conversely also compliments being received. It will inevitably create specific anxieties about local services being accessed, and some observations have been made about particular examples of services under the public and media spotlight.

National platform

More NHS Wales-wide working

259. NHS Wales is not sufficiently sharing good practice, innovation and what works in respect of effective complaints practice. This includes better sharing of local lessons learnt in respect of serious complaints. The Review has demonstrated that complaints teams have not had much opportunity to use each other as networks of support and the Review has helped create some broader relationships just through bringing teams and individuals together. A specific comment was made that North Wales hospitals and services can feel isolated at times.

My reflections

260. Better training to help doctors to communicate should also be put in place in the view of many patients. As I have already indicated consultants in some cases can be seen by the public as aloof (perhaps because they are busy or focused on the clinical task in hand or assessing the investigations received). Patients can be anxious in respect of their seniority and therefore may not question their views. There is a case for training junior doctors to follow up with easier explanations and to spend time communicating in a softer manner to patients. I also believe this would be greatly appreciated.

261. This can also apply to senior nursing staff and their junior nursing team members. More effort can then be placed into developing the skill of asking questions and listening to the answers a necessary skill set to ensure that patient's needs are met with and that they are not just a part of a systematic approach. There is the potential to turn off the tap of complaints complexity completely by training in softer skill sets for those at all levels of contact with patients and in the one metre zone.

262. Communication is clearly fundamental to supporting the NHS to improve. The point here is whether staff across the organization, from top to bottom, understand how to communicate between their teams through the organisation matrix and then out with their patients.

263. I think there is a real opportunity for an NHS Wales customer care programme that in the right format can be used to create a values environment for the way every individual member of staff should approach patient care, in both clinical and

non-clinical roles. I have been pleased to see some evidence of customer care training undertaken but its take up and consistent implementation is variable. I have also heard more negatively of training sessions being cancelled due to resources and workload pressures to release staff. My point is that it is relying on individual organisations to do their own thing and the pockets of innovation that have broken out are not consistently shared across NHS Wales. There are excellent examples of NHS Wales initiatives targeted at providing a consistent message and skills to all staff at all levels, such as the 1000 lives + Improving Quality Together (IQT) Programme. This has been designed to set out different levels of skills from bronze, through silver, to gold, but aims to cover all staff at the bronze level through an initial training programme that is web-based and takes no more than 2 hours. This type of innovation and approach which has been well-received and has already covered around 10% of the NHS work force, could be developed and scaled up on an all-Wales basis. Describing the values around a patient care environment built on compassion is core business for the NHS and would help to motivate a different scale of understanding across NHS Wales. A customer care philosophy requires a regular need to ask 'How can we help you?' A sense of common purpose and values are important for any leading organisation that is ambitious and wishes to achieve excellence.

264. In other words, for internal customer care, treating individual teams as if they are your customers up and down the organization is the starting point. Critically, it is important that follow through takes place and that teams are allowed, indeed empowered, to take issues from start to completion. I would ask whether there are clear guidelines for good communication. I have heard so many staff members say the sentence "it is all about the communication" but to me it is almost the same as just saying good morning. It seems to have become a catch phrase that just lightly slips of the tongue. But I do not think that the true physical meaning of this is understood. Communicating with people is actually hard work. It is a skill set and a critical one. It cannot be assumed and needs training and you need to know what it is that has to be communicated in the first place.

265. As advocated earlier it is necessary to put the patient journey at the centre of the process being aware at all times of their conditions and needs. Continually asking, listening and caring for them making their stay feel as close to their home life as possible. This is especially true for older people as they move into a new and unusual environment. Given the changes in demography already happening this needs extra patience from the clinical staff and all teams involved to allow them to respond actively. Careful and considerate communication is always going to help patients to enjoy their stay in hospital (even the most seriously ill need to enjoy their stay, be treated well and feel in good caring hands). Evidence shows that this aids a faster and better recovery. In my view it is not asking much to be kind and considerate to people. It is often the small things like this that will make a huge difference.

266. In my view, developing a better and more compassionate bedside manner will lead to the concerns numbers reducing. If complaints reduce, then the management of complaints will also reduce. At the moment it seems as if PTR is used as a catch all for all levels of complaints. For many junior staff a referral to the PTR process is the immediate step especially if the complaint is above their experience levels. However, complaints that become formal and get referred to the PTR process will often take significantly more hours rather than the simple and early resolution of concerns that could be managed.

267. From the start of the patient journey from home to hospital through their medical treatment to their care in the wards and back to the community the establishments must be organised correctly and trained to deliver the best in all aspects of a seamless patient journey. Treating conditions for patients needs to be expanded to deeply involve the family and carers. I have heard the Minister refer to his expectation for co-production; this is something NHS Wales must step up to and requires a different attitude and philosophy that is about dealing with patients and not to as perhaps is reflected by the traditional NHS model. Families and carers are a vital part of the patient's life and vice versa. Teaching families to be a part of the care also needs to be undertaken ensuring that they can understand circumstances to the full. Treating the condition, teaching the family and engaging them in the nursing allows them to accept circumstances and help as much as they can which is usually their desire. This will also help to reduce concerns and complaints.

268. I have referred to an increasing numbers of requests to clarify where an independent view can be gathered and what recourse there is for an independent outcome, notably where difficult complaints are being pursued. This requires a response centrally to describe how the current system achieves this. However, views have gone as far as considering whether an independent NHS Wales advocate or regulator for complaints can be created. This would keep up the pressure for complaints reform and ensure, particularly post this review, that there is an ongoing and active improvement in the way complaints are considered and handled. It can range from adapting existing functions and structures through to a more independent office with secretariat. The balance of such a role is critical as it would have to be able to apply pressure and re-educate at the same time would have to be carefully considered.

269. I would suggest the potential is explored for an appointed complaints regulator to oversee the PTR scheme and complaints platform in Wales. If this were created, it should:

- Be a full position with investigative powers
- Ensure that the basic principles and code of conduct of PTR are adhered to.
- Each hospital board chair should be accountable to this position.
- Also with power to decide quickly on independent review.

- Accountable to the public overseeing and reporting the issues and findings of incidents, concerns and complaints and the relevant action to prevent further repetition of the same complaint.
- A champion of complaints who also oversees the standards of the PTR scheme.

270. There has been much discussion on the extent to which independence and objectivity can be secured within the process. As a principle, it certainly seems difficult to rely on a system where complaints are referred to those about whom the complaint has been made to provide a response. However, most Health Boards and Trusts seem able to gauge the more serious complaints that need a high level of investigation and where often an external perspective or expert view may be needed in order to determine poor practice and liability.

271. There seems to be a need to distinguish lower level complaints that can be discharged quickly and may often only be seeking clarification, from those where a complainant would expect a higher level of investigation to take place. Outside of the individual Health Boards and Trusts there is definitely some confusion about from where such independent investigation can be requested. It can be quite a confusing for those seeking to make a complaint, with various agencies seeming to have a partial role to provide support from the Ombudsman's office, through to Health Inspectorate Wales, through to Community Health Councils and even through contact with Assembly Members. Even a simple Google NHS complaint search will take you to a number of different government based organisations.

272. The avenue for an independent challenge within the existing system needs to be clarified and described; at the same time this opens up for me a genuine discussion point about whether such a high profile process such as complaints needs a higher level of independent champion to be able to support complainants and their families through a complaints process. Given the different options above, this needs to be duly considered, but there may be opportunities within existing regulation to reaffirm the specific role of an existing agency to act in this manner.

273. I have particular views in respect of how independence can properly work in the setting of small individual practices where inevitably a complaint being made will feel very close and will be initially investigated by the practice itself. I accept that there are other mechanisms in place to review what can be more serious complaints, including mechanisms that can be led more by the Health Boards; and in the most serious examples of professional practice, of course there are professional referral mechanisms in place overseen locally by Poor Performance Panels and up to and including referral to the relevant professional regulatory body such as the General Medical Council.

274. From my perspective informed by these recent weeks, one of the strengths of NHS Wales should be the ability to develop a national platform and infrastructure for change and innovation. I acknowledge the structures that are in place and the individual accountability that follows for the 10 Health Boards and Trusts in Wales. However, they have a fantastic opportunity to routinely share, innovate and create national responses. I believe and I would recommend that Health Boards and Trusts with Welsh Government more confidently develop a national understanding around the way in which Putting Things Right works. This could go as far as establishing national centralised expert teams for the most serious and complex complaints (this may also help demonstrate a level of independence that has been called for), using consistent ICT building on DATIX and also the development of national complaints call centres set up to simplify the way in which complaints are made.

My Recommendations

Putting the patient first

R59 The NHS should look to its founding principles of putting the patient first and at the centre of all its activities. There must be a major improvement in the patient journey through their time in NHS hands.

R60 In order to simplify the patient's view of who is responsible for their care during their experience, a simple and clear national description of roles across professions should be made easily available. This should be translated locally into clear badges defining the individual and their function in terms that the patient would understand.

R61 In support of creating a more open relationship with complainants and patients who wish to share their patient experience, Health Boards and Trusts should consider the use of extended Citizen and/or Patient Panels routinely to create listening events and opportunities for feedback.

R62 There is a need to put in place clearer and better patient and family support through the process of making a complaint, often at the most difficult and emotional of times. There is an opportunity to better clarify the current available support from within Health Boards and Trusts, but also through other external examples of support eg CHC Independent Advocacy Service. Health Boards and Trusts should recognise and be sensitive to ongoing contact with families where concerns have been raised. In the most serious of cases there may need to be a liaison point established to coordinate the inevitable future care and contact with the NHS that will take place.

R63 It is recommended that suitable exit arrangements are put in place for those families and carers who have suffered bereavement and to ensure that they have access to support and are aware of facilities and services available to help them overcome their experience.

R64 There is an emerging and encouraging focus on co-production with patients and broader communities. It is recommended that responses to this review should include closer links with patients as individuals and groups to create more routine contact to establish better and more responsive local complaints management. Health Boards and Trusts should

properly consider the ongoing engagement of complainants in future actions and monitoring arrangements. There should be routine mechanisms in place to allow for complainants to come forward not always through use of formal correspondence. It is recommended that initiatives such as carers and concerns clinics which have been observed, should become commonplace across all health organisations.

R65 It is recommended, beyond complaints, that Health Boards and Trusts expand their range of activities and contacts to draw in direct and personal experience of services. This should be supported, but not exclusively so, by actions being taken forward under the national patient experience framework.

R66 It is highly recommended that NHS organisations compel themselves to the development of more activities with wider communities and think outside the normal NHS culture. This would include building on best practice from other organisations.

R67 As far as being responsive to the needs of children, it is recommended that Health Boards contact the Children's Commissioner to engage in better practice in this area and to review their provision at the relevant places of their organisation.

Training: complaints and customer care

R68 In supporting a customer care approach it is recommended that a strong engagement and communication programme be taken forward in respect of NHS Wales and all health organisations, ensuring the involvement of staff and staff organisations. This will be critical in delivering a positive patient-focused customer care programme.

R69 NHS Wales should introduce a national customer care programme to focus on values, getting the basics right and a focus on patient experience. This is a positive opportunity to reinforce NHS Wales identity as a national service, delivered through local structures. The customer care programme should also reinforce a continuous quality improvement focus and wish to provide better patient services on a consistent basis. This NHS Wales customer care programme needs to be included at the same time in all induction programmes for new staff.

R70 The programme should build on and learn from positive staff experiences implemented across NHS Wales through the 1000 lives+ programme, transforming care and Improving Quality Together bronze training. A specific recommendation is for the customer care programme to be facilitated in a similar manner to the Improving Quality Together (IQT) programme successfully facilitated by Public Health Wales and the 1000 lives+ team.

Making the system fair and independent for complainants

R71 It is recommended that greater use be made of the ability to access independent advice in support of local resolution, rather than rely solely on local clinical opinion.

R72 NHS Wales needs to demonstrate further that the PTR scheme is fair and independent for complainants. NHS Wales needs to clarify the existing system for accessing independent evaluation of complaints and concerns, including the nature of complaints responses. Specifically, this includes describing the current respective roles of CHCs, HIW and Public Ombudsman that users have commented are currently confused.

R73 It is strongly recommended that Health Boards and Trusts must implement

mechanisms that demonstrate, in handling local complaints that clinical teams, against whom a complaint has been made, do not investigate themselves. Health Boards and Trusts need to validate their local investigations and responses by ensuring further independent advice can be taken, when required, and in consultation with the complainant, in order to further the professionalism and quality of the investigation. This should include sharing the external report openly with the complainants.

R74 There has been a clear argument for a national complaints regulator. If the existing system cannot be improved to clearly demonstrate independence from a patient perspective, it is recommended that the appointment of an independent NHS Wales complaints regulator should be made to operate within the boundaries of the PTR scheme and as a complementary function to the Public Ombudsman. This officer should be able to operate independently of the current organisations and should be empowered to order investigation within the NHS PTR scheme. A proposed set of duties for this proposed role is included at Appendix 1.

R75 It would be better for the regulator to be separate from current organisations with regulation roles, eg HIW, CHC, Ombudsman etc. However, an appropriate step may be to allow the role to be located within the CHCs in the interim, as part of a clarification of their roles. The regulator should chair a routine quarterly meeting of Chairs and Chief Executives to investigate the monthly and cumulative results of PTR to ensure that Health Boards and Trusts are correctly implementing the scheme.

R76 The redress process should also be subject to the Complaints regulator, once established. It is recommended that once the investigation has taken place under this independent authority then the outcome should be final and accepted by all parties and formally closed from a local complaints perspective.

R77 This function should not replace the role of the Ombudsman but be focussed on the maintenance of PTR regulations and its delivery.

Communication

R78 There is a need to further develop teams of employees who understand meaningful communication for the relevant workplace. Communication should be part of the formal training process for those handling patients, carers and complainants. All Health Boards and Trusts should implement suitable communication training in this respect.

R79 The review has focused on the specific need for effective training in customer care and communications. However, it is also recommended, whether under the auspices of this review or other mechanisms, the NHS, including educational partners, looks at the skill-set needed to pass on bad news often in the most difficult circumstances. This needs to recognise the nature of a team-based approach in delivering care. Teams need to be better coordinated in their communication in this concern.

R80 As part of general training on effective complaints handling, there must be a focus on providing frontline teams with the skills they require to handle concerns without delay as it happens or as it is reported. This includes correct and proper training for investigating incident and particularly complaints.

Patient journey

R81 Frustration has been expressed about the complexity of current boundaries between primary and secondary care, social services, general practice and dentistry all of which have different incident and complaint mechanisms. This includes trying to coordinate vulnerable people such as the young or elderly across these areas of support. This area should be reviewed with the purpose of simplifying all into a single and seamless experience for the user. It is recommended that specific advice be taken on this issue from the respective Commissioners for Older People, Children and the Welsh Language.

R82 There have been complaints about poor care coordination and handover across different parts of the NHS system. It is recommended, as part of local strategies for care, that better mechanisms for navigating and supporting patients through their care and treatment system should be put in place.

R83 As part of a customer care ethos, every organisation should review the way in which it positively welcomes patients into its services, from first contact and throughout the experience. It is recommended that this include improving the nature of correspondence, the ease of finding a service or facilities, regular contact to update on progress and extending basic courtesies in day-to-day contact.

Celebrating positive experiences

R84 It is recommended that as a positive reflection of good patient experience, the level and nature of compliments received should be promoted and reported within Health Boards and Trusts. These act as a positive commentary on progress and improvement and a focus on good quality patient care. It is also necessary to focus on positive activity that is also prevalent within the NHS. There is a weakness in the current NHS organisation to regularly and consistently celebrate this across structures. Although focusing on complaints is good for the improvement of the organisation it cannot be allowed to create an environment where complaints investigation is the only source of improvement.

R85 There has been good evidence across the NHS of local clinical teams celebrating success in quality outcomes, for example, where wards have not experienced any infection for many weeks and months. It is recommended, that those areas receiving zero or limited numbers of complaints be subject to positive support in this way.

Staffing for compassion

R86 It is strongly recommended that there should be ongoing implementation and support for the excellent Free to Lead, Free to Care initiative (Transforming care) focusing on empowering Ward Sisters. The momentum and outcomes from this seem variable across Wales, but when working well have demonstrated a real impact on excellent care and outcomes.

R87 Correct staffing levels, with trained up teams, operating under professional leadership must be enhanced so that compassionate care can be provided. Compassion takes time so it should be strongly recommended that management assesses and provides correct human resource levels in this area, building on initiatives for minimum staffing levels introduced over the last year.

Working under duress

R88 It is strongly recommended that staff surveys and their outcomes are treated openly and honestly and reflected deeply into the organisation with full Board support. It is also strongly recommended that using a wide variety of technology, personal contact and team working, all avenues of communication with staff be put in place. This should allow either community or individual discussion on concerns and actions to take place, and in open or private forum to create an open and responsive culture between organisations and employees.

Use the national platform

R89 As part of simplifying the PTR process, or at least the manner in which it has been implemented, the number of internal complaints contact points needs to be reduced. It is recommended that this should be done effectively within each organisation, as part of its refresh of its local PTR process following this Review. However, there remain opportunities to create contact points at a national level, emphasising the NHS Wales identity in respect of complaints management.

R90 NHS Wales is duplicating activities locally that in other industries would be done on a regional or national platform. Focusing on complaints handling, there should be a serious review of ICT infrastructure, national expert teams, national mechanisms for learning and sharing lessons and the potential for centralised call centres that can signpost to local teams and responses. It is necessary to reform and re-strengthen the PTR scheme across Wales on a national basis. This means putting in place the correct infrastructure in terms of same operational capability in each Health Board.

4. Identify how the NHS can demonstrate it is learning from patient feedback

Themes from stakeholders and users

Importance of data and information

Data and information

275. There are many examples of data being collected at all levels of operational and corporate actions. However, this data is not always being used consistently and is perhaps not always being used to inform on the areas of good practice. The complaints process from a more informed view of the best measures to support good complaints management and mitigation.

Sharing of information

Good practice exchange

276. There needs to be a routine focus on sharing good practice, what works and importantly what is generating positive patient feedback within the PTR process. This review has revealed through a range of comments received that there are

many good ideas about how the process can be improved. There are also broader opportunities to be drawn in general lessons and good practice from right across the NHS.

Standardising complaints reports

277. Through the review it is clear that all Boards are openly reporting their complaints performance regularly and through Annual Reports. However, to aid comparison and learning there is no standard template and all the reports are local to each organisation. This seems a missed opportunity for NHS Wales. Even better if the report could be formatted in a way that could be easily understood by those outside of the NHS and the general public!

Learning from complaints

Learning lessons

278. There is a lack of confidence that organisations are genuinely learning from change. There seems to be data showing recurrent themes and repetition of errors. If organisations are not learning as we would expect, this needs to be challenged; if they are, they need to be more effective at demonstrating this and communicating it. Lessons need to be learnt for Wales as well as within individual organisations. A number of stakeholders saw a real positive about using the PTR scheme to ensure the learning was in place and spread.

Learning and avoiding complaints

279. There are specific complaints that require action plans and assurance that all commitments have been put in place. However, users commented on wanting broader system changes to take place on some core service areas, such as problems with outpatient appointment systems, difficulties in booking ambulances, repeat examples of operations cancelled. There was a call for evidence to show that the system, not just individual complaints, is learning from the more repetitive areas of service difficulty, particularly when these are critical to patient experience. For some complainants, they have noticed a lack of actions when they have accessed other local services, which reinforce their feeling that their concerns have not been taken seriously.

Learning and improvement

280. There is a difference between learning for improvement versus accountability and blame. It takes a stronger system to deliver the former, when the inclination can be to implement the latter.

A system that can focus on getting the basics right

281. Even in fields of advancing technology and practice we need to ensure our care is provided with the basics lined up first; starting with dignity and compassionate care and a proactive approach to simply asking how patients are.

The routine of checking results

282. Complaints and incident management needs to be the routine not the exception. There needs to be a routine in place of constantly checking results, outstanding complaints, actions monitored and response targets overseen at the highest levels of the organisation.

Dealing with serious complaints

283. Given the lack of liaison across Health Boards and Trusts, there has been some comment about whether the most serious complaints should go to a mechanism such as a National Safety and Quality Forum in order to place attention on the most serious cases, but also to allow a better mechanism for sharing learning.

Visible individual cases

284. There are publicly visible cases that are attracting a profile. It is important that major lessons are drawn from these particular users bad experiences. Also the way in which they are addressed will act to help the NHS improve its complaints management and systems.

Analysis and themes

Actively using the regular contact and information arising from complaints

285. Some of the complaints experiences show a classic case of an organisation not using its contact with its users to reflect change for the better. A company running itself in this manner would eventually have no purchasers of its products and therefore not exist.

Triggers for Action

286. Although there is a general commentary on the NHS needing to better present its local progress and improvement, in respect of complaints there has been some comments received about better bringing together indicators that should trigger concerns processes locally, including complaints. There should be better triangulation of relevant concerns information to trigger local – and if necessary national – action including aligning quality and outcomes, complaints themes, complaints responsiveness, incidents, patient satisfaction and staff surveys.

Addressing complaints themes

287. There are underlying service areas for improvement that if addressed would lead to a reduction in complaints. We need to ensure that as well as improve the complaints process, that we target causes of complaints. As a simple example if high numbers of complaints are received in respect of waiting lists, then actions to reduce waiting lists would support the ability of the PTR process to deliver

Case studies

288. There have been some very powerful case studies shared within the review, sometimes revealing upsetting and harrowing experience, but examples where there have been opportunities missed to resolve the complaint. A focus on case studies, that capture what this has meant for individuals, is a strong motivation for driving improvement. There has to be a commitment in which Boards and those working at the highest levels can receive and reflect on individual complaints regularly within the Board processes.

Adopting and creating innovation

Ensuring changes are made

289. It is important that any recommendations to improve PTR need to be delivered with clear implementation plans and monitoring in place. There have been previous examples of commitments not being fully followed through and this complaints review is perceived as very important and an opportunity to make critical changes. Welsh Government is also recognised to have a role to drive this change on the national stage.

Aspiring to and delivering innovation

290. There was general discussion about needing greater innovation around solutions that can tackle systemic problems across the NHS. At the same time there was support for the review to promote some innovative solutions in respect of achieving excellence in complaints management. There are clearly innovative examples and good practice examples across NHS Wales, but it is simply not being shared as a matter of routine. Examples, such as open complaints clinics, complaints dashboards to Chief Executives, redress panels, patient advocacy services and attachment of senior clinical teams to the complaints team are all examples that make a difference to the complainants experience.

Traditional examples of delivering clinical and non-clinical services

291. Some of our ability to improve and respond better to complaints requires the traditional systems in place to be changed and improved. Does it give the public confidence to still see trolleys of patient documents being wheeled around hospitals and transported between sites rather than full use of ICT and electronic records? There are opportunities for innovation that would probably lead to complaints being avoided.

Common approach with social services and other settings

Learning from social services

292. Social services have introduced a new complaints procedure drawing on PTR experience, and which has been subject to consultation. They are based on the

public sector model complaints policy previously issued by the PSOW (which in itself was based on and followed implementation of PTR). The new arrangements do not come into place until August 2014. In addition, like the NHS, Annual Reports must be reviewed and published. What is helpful to this current review is that an evaluation is also undertaken about how the individual complaint and processes were handled. The first stage is based on local resolution in a similar way to the NHS. If this is not resolved then there are criteria for having a formal investigation carried out by someone independent of the local authority concerned; this could be someone from another Local Authority, Health Board (if relevant) or an independent expert. This latter element could be considered for introduction in the NHS. Currently, the NHS can agree to commission independent reviews of cases, usually linked with the redress or negligence but not always.

Integrated teams

293. There are increasing examples of complaints that operate with teams involving both NHS and non-NHS members of staff as new developments are put in place around better joint working with social services. The complaints process needs to account for such developments, there will be more shared working in the future.

My reflections

294. Data, that is good data, is really important to set a baseline for improvement. Statistics are not maintained or not available to be able to clearly measure progress in most aspects of what is involved in a complaint and to measure how to improve standards as a result of investigations.

295. The outcome of what can happen can also be influenced by the analysis of the issue or complaint and subsequently innovating change. You can answer thousands of complaints within thirty days. However, if you do not pay heed to them and use them to change the method of your work you will be answering thousands of complaints forever and causing stress for the users.

296. If you want to know what is going on with your patients and families then the easiest way to find out is to simply ask them. This could include check in and exit interviews with ward sisters, and receptionist to find out if they are happy with their time in hospital and with all aspects of their care. Importantly, staff should be looking to see if they need help before they leave. To give a business example, if you visit a good quality hotel you will be on the radar of at least five people as you step through the door. Your stay would be constantly monitored and service provided to your request levels. You would also check out and be seen off the premises in a respectful manner. In the meantime your data and comments would be scrutinised and reflected into the management team on a frequent basis to allow reflection and improvement to services. You would also see your

personal changes applied to your next stay. So my proposal is whether this type of media could be used for patients as well and to further increase the intelligence for general care levels?

297. I am an advocate for a change from retrospective PTR, albeit that the process should be performed in an exemplary manner, to doing it right in the first place!
298. Patient support officers and all operational staff should be able to respond to individual patient concerns and respond according to the system or process in place. They should have a full understanding of the scheme and be able to ensure help and assistance with concerns and complaints is close at hand. These processes and reports should be linked to the same analysis as the complaints and incidents reports so that proper data can be collated on the patient journey and reduce incidents and complaints at source and not to repeat the same mistake with another person. Together with learning from what goes well, great steps forward in patient journey care could be made and this would reduce the level of complaints and turn them into letters of thanks and endorsement to proceed with the improvements.
299. Most importantly to achieve this you have to study collected data all the time as the trend evidence will be in that data. Boards and Chief Executives need this to be able to break the mould of low morale and encourage teams to produce better services for patient journey needs. Specifically the NHS needs to be made better from learning from what goes well.
300. The faster the complaint is learned about and the immediacy of the action to rectify it is started the safer place the hospital will become. This is also a good way to manage the quality of the complaint handling to ensure it is handled once and analysed correctly and the outcome shared as good practice throughout the organisation.
301. It is necessary to identify how the NHS can demonstrate it is learning from patient feedback. This oversight of individual complaints, the development of actions from trends and the ability to show how individual actions have been implemented and are monitored are very important responses to give confidence that NHS Wales is learning. I would strongly advocate that learning from complaints must be spread more broadly and that there is a need for Health Boards and Trusts in Wales to share routinely and in depth the issues arising from complaints, incidents and concerns.
302. The NHS needs to recognise that just issuing huge process documents does not actually make change however well intentioned that they are. In fact I have found some of the documentation so difficult to read that I cannot consider that it is practical for hard pressed staff to have the time to read either.

303. People make change! But to do this they have to be empowered and to create empowerment you need to be on a platform that teaches people to accept autonomy and responsibility together. From this accountability will come.
304. To make this happen the system needs to be developed to be free of blame and bullying. No individual will act independently if they feel they will then be crushed by blame. All organisations therefore have a duty to ensure that those doing the various roles are well enabled through proper and correct training to carry out their jobs to the required standards. In its most simple form this means ensuring that as a basic start position everyone knows how to do their job to the required professional levels and standards set down by regulators or their relevant bodies. This is the start of all good practice and is making the people first before you let them proceed to carry out that role as an individual person. This training is the start of preparing people to be accountable for what they do in their role. It is the absolute responsibility of the organisation to ensure that the people it employs are developed in this manner.
305. It is possible to set out some innovative solutions that will help maintain the priority around complaints and ensure responses are facilitated better. However, my own reflection is that the NHS needs to emphasise that approaching this area with some common sense, some compassion and a simple interpretation of what patients are seeking may help most. Patients and relatives more often than not need to speak to someone as the issues arise and I am sure the NHS in Wales generally would wish to anticipate and prevent formal complaints, irrespective of creating an open environment for them. I am sure a simple apology and a commitment to rectify the immediate circumstances would prevent a large number of incidents escalating. It is also important to pass on empathy for complaining, remembering that I have referenced that every complaint is a gift. This small step allows complainants to feel that their comments are valued and that they are doing something positive to improve the organisation and their situation.
306. As well as formal complaints, and without creating a whole industry, there must be a mechanism to capture verbal complaints at the frontline. Whether this could take the form of a basic spreadsheet, or whether DATIX can be adapted to just be more flexible; as a source of information, the availability of such information to the system is really important to mainstream complaints responses and learning. This also allows for some way of acknowledging the complainant and providing a receipt of the issues. Simply passing on the details of the Chief Executive and the formal Putting Things Right process is for me not taking responsibility for the immediate circumstances. Advice also needs to be given on what happens next and what actions are taking place. I believe that such informal complaints need a fixed limit on a response and are clearly not the type of complaint to be thrown into a 30 day PTR response. As I have promoted earlier not every complaint needs to be turned into a full-blown investigation; it is as

much of a skill to resolve these lower level complaints professionally, with courtesy, as it is to ensure the highest standards of investigation for the most serious complaint. This is not to say however that some of these individual complaints will not need to be escalated within the broader system.

307. I have focused a lot on the overall analysis of complaints and trends at the highest corporate level, with an expectation that this is to be reviewed and actioned at Board and Chief Executive level. However, any successful complaints system needs to have ownership right down and through the structures. All complaints should be heard daily at department level and at least weekly at Senior Team level. The volume of complaints at the Board level, once they have been aggregated up the structure, are such that it can be more difficult to quickly understand the nature of the complaint and ensure that prompt actions have taken place. At the department level, the review by the staff of a single or fewer number of complaints has greater impact, not least to generate a wish that the event or incident will not reoccur. I have been impressed by local initiatives across NHS Wales, such as the way in which wards pause and celebrate significant numbers of days on a ward without an infection or incident. I would put complaints into the same category and suggest that locally and corporately organisations find ways in which they can pause, commend and celebrate areas that have gone for particular periods without any complaints. This reinforces what success looks like at the individual department level.

308. I have had contact with the Transforming Care programme which as a nursing initiative is intended to better empower individual wards and to allow a focus on visible quality and safety outcomes. I have seen wards with a very visible tracking record on their walls of their recent complaints. For those wards that have gone many months without a complaint, I have also seen the impact of receiving a new complaint after a protracted period, but also that this has led to a very genuine and professional response to the complaint. For me this reflected a simple pride in the management of complaints and it was no criticism to have a new complaint, but I could see that staff simply did not want to repeat this again having established a high standard of zero complaints. For the benefit of patients and users this attitude needs to be developed and fostered all through the NHS in Wales.

309. In terms of active monitoring, a simple traffic light system can be used as the tool for the complaints progression. Stagnant complaints would be identified immediately whether these are held up or not. I would have expected DATIX to be able to act as this tracking database, but there are some examples in place across Wales that show how departments have developed ways to ensure that timeliness is at the forefront of the complaints response. This monitoring is not yet standardised across Health Boards and Trusts.

310. I have experienced an NHS that has adopted a continuous improvement approach to a range of service and quality changes, again very visibly portrayed through the 1000 lives + programme. However, this is less visible within the complaints system, which has made me feel that this is operating more in the background than as core quality business. I would wish to positively see the implementation of a continuous improvement culture around complaints. In order to deliver a positive experience, the NHS has to ensure that the patient is put first. Therefore, all key messages, systems and processes must be designed with their highest expectations in mind.
311. As a result of poor performance in complaints management, I have been impressed by the system put in place by one of the Health Boards in Wales that has empowered a group of very capable clinicians to re-develop the complaints system and reduce the large number of serious complaints back log in the system. This has meant targeting a backlog of concerns as well as finding a way to deal better and more immediately with new complaints emerging. For me, complaints teams wrapped around with strong clinical backgrounds and a very senior professional involvement are more effective and more rounded. Some of the obstacles can be caused by professional concerns or defensiveness and it allows these to be tackled head on. In industry, teams dealing with complaints will have a spread of all of the requisite experiences in the services as well as excellence in coordination. This example was the closest I could find to this.
312. The common thread of complaint from complaints teams is that the critical people needed to manage the throughput of the complaint are usually separately located throughout the organisation. This in itself has resulted in delay, poor feedback of information and a lack of understanding of the feedback information. This also demonstrates again this balance of excellence in oversight and administration, with experienced complaint handlers, but an advantage in overlaying the clinical support and experience. Poor initial discussion with complainants, often focused on the clinical knowledge needed, can impede the relationships needed to make progress.
313. Similarly, the issues facing PTR complaint handlers should be managed out of the current system by adapting the teams into a one-team concept that can end to end manage a complaint or incident with quality. Although a rapid response is important, the quality of the investigation is ultimately more important as any complaint needs to be fully explored to the satisfaction of the complainant and as a method of the organisation learning. Even if all efforts have been made to prevent incidents becoming complaints it is possible for complaints to come through and they need to be dealt with professionally.
314. Complaints don't just occur Monday to Friday between the hours of 9am to 5pm. The complaints infrastructure needs to acknowledge that complaints can occur at any time of care, treatment or contact. This means that from an

315. infrastructure perspective it is really important that individual teams feel supported to resolve the complaint early and as it happens. However, at the same time, I believe there is a need to ensure a broader responsive team is in place that can respond across 7 days. This is again why I have put an emphasis on patient advocacy teams that feel that they are a daily mechanism that should be in place in support of any immediate attempts to resolve the complaint at the department level. I have noted that one of the Health Boards has dedicated senior staff working weekends and evenings to reduce incidents and to ensure the quality of care. Complaints clinics have been put in place in evenings to allow better flexibility for those with concerns to be able to attend and outline their experience. It needs to be clear how the complaints and concerns system works outside normal hours, particularly in respect of very serious issues.
316. The NHS must learn to value a complaint and its content, analyse it, learn from it and innovate. The NHS needs to accept mistakes happen, but own up to it to prevent it from happening again. Hospitals of their nature can be dangerous places and as a result the general public would appreciate honesty and candour in their dealing with the NHS. This should be a basic patient right not something that is decided by the NHS and informed to users on a need to know basis.
317. I have a general concern that these areas of emerging good practice and innovation that are being developed in-house within the individual Health Boards and Trusts are not being shared. My general challenge is how these types of innovation do get shared around the rest of the organisations in Wales. Again, it seems that NHS Wales is not taking the full opportunity of its national platform and identity in order to create a learning and innovation culture across organisations.

My recommendations

Importance of data and information

R91 It is recommended that a clear, consistent complaints dashboard should be developed to support reporting of complaints and concerns at all levels, including oversight of complaints responsiveness within departments, at Board level and to support collective review at an all-Wales basis. This should also act as a trigger for quality concerns and align to local quality monitoring.

R92 As part of producing better information in respect of complaints, concerns and compliments themes and process, there should be a review of how data can inform outcomes and not just process measures.

Sharing of information

R93 Complaints clearly operate in an environment of confidentiality to all, which is necessary to underpin effective relationships between the complainant and the organisation. It is recommended that the confidentiality arrangements underpinning PTR are reviewed and clarified as part of the changes that will be implemented following this review.

Learning from complaints

R94 There is a need to give confidence by focusing on the basics that should be normally in place, for example, lack of everyday items such as blankets and pillows, understanding how critical equipment works, noise levels, talking as if patients are not there or no help when needed to toilet, etc. It is recommended that Health Boards and Trusts need to focus on resolving simple issues and basic expectations in order to reduce and avoid complaints relating to fundamental care.

R95 Where commitments are made to make either individual or system changes arising from a complaints process, a clear action plan must be put in place and communicated to the complainant, but there must be a more effective system for tracking progress and achievement of the actions that have been committed. There also needs to be a comprehensive process in place to oversee and complete the cycle of lessons learnt and implemented.

R96 There should be a particular focus on supporting learning from complaints and sharing of the actions at the level of clinical teams, whether ward-based, department-based or across consultant teams. Complaints should be visibly discussed by teams, and be seen to do so. At the service level any complaint or concern, and the identification of potential themes, should be the subject of daily review. Complaints and concerns should be reviewed as a minimum weekly at Divisional level. Chief Executives and Executive Teams should as a minimum wish to review emerging concerns and complaints resolution on a weekly basis, in order to lead by example on the profile of effective complaints management. Boards should clearly review complaints, concerns and incidents within their formal quality and safety committee arrangements, supported by monthly availability of clear and summarised complaints information.

R97 Boards have meetings in public and this provides a good platform for better public awareness and developing confidence in sharing and resolving issues in an open environment. All Boards should formally receive a complaints overview within their public Board meetings.

R98 Formal learning mechanism must be in place at all levels from Board to individual services to ensure that learning from complaints and incidents is reviewed regularly and seriously, but more importantly that change and actions are taking place and being shared.

R99 Mechanisms should be in place to support staff when affected by a serious complaint and to provide a local response that permits the individual or team to revert to their core function effectively.

R100 There are and may always be publicly visible individual cases that attract a high profile. As they arise, it is recommended that the lessons learnt from these experiences be visibly addressed in order to act as a trigger for improvement for better care, services and complaints management.

R101 There has been some comment on needing to demonstrate escalation in respect of the most serious category of complaints that are received across NHS Wales. NHS Wales should either satisfy itself that its current processes for serious complaints is robust, or should consider whether a new mechanism, for example, a National Safety and Quality

Forum, could better support the learning and response on these most serious of cases arising from complainants.

Analysis and themes

R102 There is a need to ensure that all Boards understand the themes and analysis on a local and an all-Wales basis to identify the larger systemic issues that need to be managed out of the system. Solutions need to be shared regularly. In terms of avoiding future complaints, Health Boards and Trusts must routinely analyse complaints themes and escalate their attention to this rich source of information about their patients' experience.

R103 There must be a mechanism to ensure that complaints trends, notably around areas of system failure eg fixing environment, lack of basic items, outpatient appointment processes, difficulties with ambulance bookings, etc have clear action plans put in place as these represent avoidable complaints once an effective system is in place. Health Boards and Trusts need to ensure that they have the management capacity available to respond to system failures and subject these to improvement processes.

R104 In the current system, it will be rare for complainants to receive future contact confirming the implementation of changes or improvements that have been monitored. It is recommended that improvements to systems should be fed back to complainants who originally highlighted the difficulties, even where the complaint itself has been closed, in order to give greater confidence to them individually and their communities more broadly that learning and changes have taken place.

R105 Building on the positive experience of using patient stories, Boards should review individual case studies as a matter of routine within their receipt of complaints information. It is recognised it is not possible to use every individual experience in this way, just from the numbers involved. However, a clear focus on individual patient experience of care and complaints process brings data to life.

Adopting and creating innovation

R106 There is much greater opportunity than is currently taken to share innovation and best practice in both complaints handling and resolution of complaints. It is recommended that Health Boards and Trusts better share the positive initiatives that have been highlighted during the course of the review. A constant review of good practice in complaints management should take place and be maintained to ensure that the best practices are shared and incorporated into the scheme.

R107 PTR is not working as it was intended to. There is a need to join up incidents, inquests, complaints with investigations and learning to inform improvement and reduce harm and costs.

R108 Training for those involved on the PTR processes should be national and cross checked for new and innovative approaches which can be quickly shared across the Health Boards.

Common approach with social services and other settings

R109 Given an ongoing focus on closer working with social services and evidence of increasing integration of services across the NHS and social care, the NHS in Wales should

review the PTR guidance alongside the guidance for social services.

Chapter 6: Next steps

318. It is intended that this report will be presented to the Minister together with the set of recommendations for improving the Putting Things Right concept and process.

319. If the report's recommendations are to be put in place a set of dates and deadlines should be agreed for implementation. These should be subject to implementation review at set times, proposed to be through the review team and this Reviews expert review group, to ensure that the recommendations have been taken up and put into practice.

320. There are also some areas highlighted within this review and associated recommendations, that would benefit from broader discussion and even some element of consultation.

Appendix 1

Proposed duties of complaints regulator:

- The regulation of the PTR system for NHS Wales.
- The investigation of complaint and incident data.
- Analysing trends from complaint and incident investigation.
- Order higher and better quality investigation quickly.
- Question Boards over incident, concerns and complaints.
- Monitor change that should take place by action plan following complaint investigation by setting implementation deadlines with follow-through.
- Ensure PTR accessibility is in full view and easy to access.
- Spread innovation from the analysis of complaints and incidents throughout Wales as a learning from complaints.
- Be empowered to order best practice into other Health Boards and Trusts.
- Report and refer issues directly to the National Ombudsman, NHS DG and the Health Minister.
- Work closely with other bodies such as CHCs, AvMA, existing Commissioners and others for the betterment of patient experience.
- Regulate local patient advocacy schemes to help patients settle concerns and complaints at source or when necessary navigate the PTR scheme.

- To ensure the correct management of personal data and correspondence is upheld throughout processes.
- Ensure that the decision is accepted and the closure is final.
- Manage national public, safety and quality forum for open debate on user experiences within the NHS.

Appendix 2

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3. Delivering Safe Care, Compassionate Care: Learning for Wales from The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - July 2013
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A promise to learn – a commitment to act: improving the safety of patients in England by Don Berwick – August 2013
5. Independent Advocacy Report
Board of Community Health Councils in Wales – Complaints Advocacy Service Report 2010-2012
6. Longley CHC report
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Appendix 3

Abbreviations

PTR	Putting Things Right
HB	Health Board
CHC	Community Health Council
ABMU	Abertawe Bro Morgannwg University
ABUHB	Aneurin Bevan University Health Board
BCUHB	Betsi Cadwaladr University Health Board
CVUHB	Cardiff and Vale University Health Board
CTUHB	Cwm Taf University Health Board
HDUHB	Hywel Dda University Health Board
PHW	Public Health Wales
PTHB	Powys Teaching Health Board
VEL	Velindre NHS Trust
WAST	Welsh Ambulance Service NHS Trust
PSOW	Public Service Ombudsman Wales
AFA	Area for Assessment
AvMA	Action Against Medical Accidents
LHB	Local Health Board
DG	Director General
PALS	Patient Advocacy Liaison Service
HIW	Health Inspectorate Wales

End of Review and Recommendations