Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Iechyd a Gofal Cymdeithasol
The Health and Social Care Committee

Dydd Mercher, 16 Gorffennaf 2014
Wednesday, 16 July 2014

Cynnwys
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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Leighton Andrews	Llafur Labour
Andrew R.T. Davies	Ceidwadwyr Cymreig (yn dirprwyo ar ran Janet Finch-Saunders) Welsh Conservatives (substitute for Janet Finch-Saunders)
Ann Jones	Llafur Labour
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Dr Phil Banfield	Cadeirydd Cyngor Cymru, Cymdeithas Feddygol Prydain Chairman of BMA Welsh Council
Maria Battle	Cadeirydd Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Chair, Cardiff and Vale University Local Health Board
Y Gwir Anrhydeddus/The Rt Hon Ann Clwyd	Aelod Seneddol a chyd-Gadeirydd yr Adolygiad o System Gwyno Ysbytai'r GIG (GIG Lloegr). Member of Parliament and Co-Chair, Review of the NHS Hospitals Complaints System (NHS England).
Tina Donnelly	Cyfarwyddwr Coleg Nyrsio Brenhinol Cymru Director of the Royal College of Nursing Wales
Keith Evans	Awdur yr Adroddiad 'Adolygiad o Ymdrin â Phryderon (Cwynion) yn GIG Cymru—"Using the Gift of Complaints"'. Author of the Report 'A Review of Concerns (Complaints) Handling in NHS Wales—"Using the Gift of Complaints"'.
Rory Farrelly	Cyfarwyddwr Nyrsio a Phrofiad y Claf, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg

	Director of Nursing and Patient Experience, Abertawe Bro Morgannwg University Local Health Board
Dr Chris Jones	Cadeirydd Bwrdd Iechyd Lleol Cwm Taf Chair, Cwm Taf Local Health Board
Mike Jones	Unsain Cymru Unison Cymru/Wales
Carol Shillabeer	Cyfarwyddwr Nyrsio/Dirprwy Prif Weithredwr, Bwrdd Iechyd Lleol Addysgu Powys Director of Nursing/Deputy Chief Executive, Powys Teaching Local Health Board
Nicola Williams	Cyfarwyddwr Nyrsio Cynorthwyol ac Arweinydd Trawsnewid Cwynion a Phryderon, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Assistant Director of Nursing and Lead on Transformation of Complaints and Concerns, Abertawe Bro Morgannwg University Local Health Board

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Helen Finlayson	Dirprwy Glerc Deputy Clerk
Llinos Madeley	Clerc Clerk
Philippa Watkins	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 8:45.
The meeting began at 8:45.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning, I welcome Members to this morning's session of the Health and Social Care Committee. I remind everyone that this will be a bilingual meeting. You may use the headphones for simultaneous translation, on channel 1, or for amplification, on channel 0. I also remind everyone to switch off their mobile phones or any other electronic equipment that may interfere with the broadcasting equipment. There are no scheduled fire alarms this morning, so if one does go off, please follow the direction of the ushers. We have received apologies from Rebecca Evans. Ann Jones is substituting for Rebecca this morning. We have also received apologies from Janet Finch-Saunders, who is unable to attend the meeting until 11 a.m. I am informed. Andrew R.T. Davies will be attending for the first half of the meeting in her absence.

[2] I would like to put on record our thanks to Rebecca Evans for her work over the years on this committee. She has now been promoted to the Government. I hope that Members will support that.

[3] **Lindsay Whittle:** We congratulate her as well, Chair.

08:46

Cynnig o dan Reol Sefydlog 17.42(vi) i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order 17.42(vi) to Resolve to Exclude the Public from the Meeting

[4] **David Rees:** I move that

the committee resolves to exclude the public for item 3 in accordance with Standing Order No. 17.42(vi).

[5] Are Members content with that? Yes. We will reconvene in public at 9.15 a.m. in order to hear the oral evidence for our inquiry this morning.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 08:46.
The public part of the meeting ended at 08:46.

Ailymgynullodd y pwyllgor yn gyhoeddus am 09:15.
The committee reconvened in public at 09:15.

Ymchwiliad i Broses Gwyno'r GIG: Sesiwn Dystiolaeth 1
Inquiry into the NHS Complaints Process: Evidence Session 1

[6] **David Rees:** May I welcome Members back to the public session of this morning's committee meeting? I remind everyone that the focus of this morning's evidence sessions is to consider the complaints process within the NHS and the report produced by Mr Keith Evans for the Welsh Government and not the health service per se or the causes of the complaints; it is more how the complaints are addressed or not addressed and the issues arising as a consequence of that. May I welcome Mr Keith Evans to the first session this morning?

[7] **Mr Evans:** Thank you.

[8] **David Rees:** May I thank you for the work you have done and the report you produced? It is a very thorough piece of work, but what we want to try to do now is to inform the process from that, and therefore we have some questions that arise out of the report and the work you have done. Thank you very much for that. We will go straight to questions because we have a tight timescale. We will start with Gwyn Price.

[9] **Gwyn R. Price:** Thank you, Chair. Good morning. Your report makes it clear that 'Putting Things Right' is good but says that there are variations in the way it operates across Wales. Could you just expand on that reasoning, please?

[10] **Mr Evans:** The 'Putting Things Right' scheme, I think, is a good scheme. It is well thought of by the people I have spoken to. It was put together a number of years ago by many different people from different walks of life working on the regulation. When it was launched, I think it was, from my research, welcomed by most people as a good step forward, but it collided with the reorganisation of health boards in Wales. So, as a result of that, it somehow got into second place. Due to the nature of the way that health boards are set up as well, I think that, in Wales, they have paid attention to 'Putting Things Right' to the best of the capability of the health board, taking into account their independence and their own circumstances.

[11] What that has led to is quite a lot of difference across the different health boards in the manner in which 'Putting Things Right' has been implemented and resourced. So, where you get difference, you can see in the manner that complaints are handled how the teams are organised and what resource is put in—whether it is the correct resource to manage the complaint at source. What is coming out at the other end of this of course, which you can see from some of the figures I looked at, is that there is quite a lot of variation in the performance from different health boards. So, whereas it was intended in the beginning to be a single platform, I think that, across Wales, it has deviated and you could say that there is quite a bit of variation. I found quite a bit of variation between different health boards in the application of the regulation for 'Putting Things Right'.

[12] **David Rees:** Thank you. Have you seen examples of good practice in a health board?

[13] **Mr Evans:** Yes, of course.

[14] **David Rees:** Yes. You talk about the variation. Is there a problem with that good example not being distributed?

[15] **Mr Evans:** Yes.

[16] **David Rees:** Is there no mechanism for distributing that information?

[17] **Mr Evans:** I think that, again, due to the way that you have the health boards organised, it is very difficult for innovation to spread quickly across the NHS in Wales. I was asked, from the point of view of industry, to make some comparisons as well, so finding what I would be used to working with as a complaints system in industry was difficult, but there are good examples of this coming along. For example, in Port Talbot, there are examples of how that particular complaints team is pulling the correct resource together. So, out of a bad set of circumstances, it is quite normal that you get recovery. That is the same in industry as well. That is driving innovation, and I think that that type of innovation that you see there could be spread much more quickly across the rest of NHS Wales if the mechanisms to do that were in place. It needs to be more of a single platform with quick sharing of information.

[18] **David Rees:** Okay. Thank you for that. I have a series of questions from individuals now, so I will start with Lindsay and then Lynne.

[19] **Lindsay Whittle:** Good morning. When I worked in industry, I was a manager with a budget of £1 million and 15 people that I was in charge of. I always made it clear, as the manager, that the blame always rested with me. The NHS in Wales is quite a complex organisation, as you have highlighted in your report, and you particularly mention accountability. Is the management too top-heavy and, therefore, is the process of complaining lost in that complexity? When you mention blame culture, who is blaming who? Can you simplify that for me, please?

[20] **Mr Evans:** First of all, what I am uncomfortable about with the word 'blame' is that what you are actually looking for is accountability. To have accountability, you need to get different parts of people's responsibility together. They need some autonomy, they need to be responsible for what they do, and they need to be able to speak out when there is an issue. When you have those things in place, where you have an open culture, people will take accountability—in my experience—for what they do. Of course, as a boss, you are responsible. You have to be accountable. I was always accountable. However, to train your people properly and to get the atmosphere right for them to be able to work in an open manner is very important. I found quite a different atmosphere in the NHS. I think that it is difficult. People find difficulty in speaking out. So, analysing what has gone wrong in order to

find out what to do next is very important to develop accountability. If you go straight to the blame bit, where everyone is just blaming everyone, that creates a lockdown. People do not want to speak and do not want to be open, and you get the finger-pointing. Some of it goes on for years. There are incidents of it going on for years like this. The thing for me is the accountability, the analysis of what has gone wrong, the improvement of it, and putting it right so that it does not happen again. That, for me, is where I would approach it, coming from my background, to try to improve issues, incidents or concerns that come up in the organisation.

[21] **Lindsay Whittle:** Just as a quick follow up, if I put myself in the position of the person who is actually complaining, about 20 years ago whistleblowing was unheard of and I would understand that people would not complain about something for fear of losing their job, but now we have all of this protection in place. Is that just words on a piece of paper that means nothing? Is that what you found?

[22] **Mr Evans:** I think that you can generally decide on the state of an organisation by the number of covered whistleblowing opportunities that are set up in it. There are more than I would expect in the NHS, and of different variety, around the whole of the NHS. So, there is plenty of opportunity for people to speak and lots of different people that they can speak to about these issues. So, this just brings me back to the content of the report—why are they not using it? To me there is a lockdown, or a fear of speaking out, even if it is done in the most private circumstances. Some of the whistleblowing, or some of the way that people are finding that they have to speak, from my interviews, even with some of the members around the table, is quite alarming—you have to have people approaching you outside of their workplace or under the cover of darkness because they are afraid to speak out. So, that is there.

[23] **Lindsay Whittle:** If ever I made a mistake in my job, with the greatest respect, no-one died. In the health service, if people are at risk, quite frankly, I would hope that people would have the confidence to speak out and managers would have the strength and the understanding, really, to accept responsibility. These are well-paid people. What you are saying is that that is not happening.

[24] **Mr Evans:** In the complaints process, there is a gap between the complaint process, I think, and the responsibility that is placed on the board and the chief executive to absolutely drill into the information that is provided in a complaint or an incident. That needs to be moved up the responsibility list in the management. Leadership of the process must come from the board and from the chief executive. The role of the board in an organisation is to manage it properly and to drill into the issues that come out of it. So, I would agree that that needs to be emphasised. The chief executive, in terms of complaints and incidents, should be seen as part of the team that is solving the complaints. That leadership must come from the top of the organisation, which will finally be accountable for what happens in the organisation. I do not have an issue with that; I always was. People can die if you do not pay proper attention to health and safety in industry or if you do not manufacture your products properly, so there is not some sort of excuse clause within the NHS. It is about proper management of the organisation that you are responsible for, and leadership should start in the chief executive's office.

[25] **David Rees:** Thank you. I will move on to Lynne, followed by Darren.

[26] **Lynne Neagle:** Thanks, Chair. Of course, the kind of culture that you have referred to applies not just to NHS staff, but to patients. I am sure that I am not the only Assembly Member who has had constituents who are nervous about making a complaint because they think that their care will somehow be compromised in the future. Do you feel that we could be doing a lot more to make patients feel that it is completely acceptable all the time to give

feedback, and are there any issues that you would like to highlight in relation to that?

[27] **Mr Evans:** One of the main themes of my report is whether an organisation has an open heart to receive complaints and concerns, or whether it is shut down and defensive. The most important thing that any organisation can do if it wants to have a good connection with its users, whether they be customers or, in this case, patients, is to be open and to have a connection and not to be defensive. I met nearly 600 people during the course of this review, and I would say that a good many of them, when they were trying to make a complaint or voice a concern, were concerned about doing that because they thought that other issues might come out of that. So, it was quite apparent in the research that I carried out, in the letters that I read and the people whom I met, that that concern was there.

[28] **Lynne Neagle:** Thank you. Your report highlights a lack of clarity in relation to the roles of things like Healthcare Inspectorate Wales, the public services ombudsman and community health councils. May I specifically ask about community health councils, because this committee had some concerns recently when we took evidence from community health councils in terms of their interaction with HIW? So, I was wondering whether you had any comment specifically on how community health councils are working with HIW and generally on their role as patients' advocates, because I very rarely find when a constituent comes to me with an NHS complaint that they have been to the community health council first. Indeed, I very rarely find that people know what a CHC is. So, do you have any comments on that and on what we should be doing to improve what is one of our key mechanisms to make sure that the patient voice is heard?

[29] **Mr Evans:** I agree with all of the points that you have just made, and they are relevant points that are in this review. Community health councils are the eyes and ears of our health organisations, and I think that, as organisations, rather like 'Putting Things Right', they are quite a well-kept secret. I had no knowledge of community health councils until I started this review. So, I think that the purpose of the community health council needs to be strengthened and that their resourcing needs to be better, having had discussions with them. I had a number of meetings with their advocacy team, and they are all excellent, capable people, in my view, whose help I would be happy to have if I was in a situation where I found that I needed it. However, there are not enough of them. So, again, you come back to the fact that 'Putting Things Right' has started, and it has, in its own way, been successful in ramping up the level of complaints.

09:30

[30] However, adequate resource to handle that needs to be put in to all parts of the mechanism, from the complaints handling teams to the community health councils. In terms of regulation, I would say that the majority of the people I spoke to did not think that the current 'Putting things Right' system had enough independent regulation in it. That is one of the strong points that I have made about regulation. In a monopolistic organisation, where you cannot go anywhere else, it has to have strong regulation for its patients—its users.

[31] **David Rees:** Thank you. Darren is next and then Leighton.

[32] **Darren Millar:** Thank you, Mr Evans, for your report and for the opportunity to have some discussion with you during the course of your work as well; I appreciated that. May I just ask you about learning from complaints? It seems to me that some of the findings of your report suggest that health boards are not always learning from their complaints and that there are recurring themes, sometimes, which pop up again and again and again, and do not appear to be dealt with. Do you think that there ought to be a trigger somewhere within the complaints system to escalate complaints beyond the health board, where there are clear deficiencies in the way that they treat complaints, and to learn from complaints, particularly

when serious complaints are raised with the board?

[33] **Mr Evans:** That is why I think that we need a regulator. That is one of the major points that I have made in the recommendation. I am sorry and quite sad—. I had some quite harrowing meetings with people and I hope that a lot of people can see that what they have said to me is contained in this report and in the recommendations that I am making. So, I am not making light what has happened to people.

[34] What is a complaint? A complaint is information. So, if you are defensive about it and you put it in a box, you miss out on information. Concerns, complaints and incidents build up a trend—if they are correctly analysed and managed. You can see in some of the complaints from a certain period of time, in the same circumstances, the same complaints coming in that were coming in three months before. For me, as a business analyst, what that is saying is that the information is coming in, but nothing is being picked up, analysed or changed in terms of that particular incident. So, there were quite a few repetitive incidents coming through the correspondence and through the discussion, and I think that how you make the connection—. Before you go to the regulator, you have to make sure that those things, like other things in the NHS, are regulated by the board at a proper level, where there is proper management of the information that is coming in. So, if the board or the chief executive is not getting that analysis—. I used to get every fortnight the analysis of every part of the company, so I knew where it was, and I met my key team people every morning to discuss the status of where the businesses were, and, as much as I could, I was out on the coalface or on the front line of the business talking to our customers and users to make sure that I was triangulating the information that was coming in. From that, you can make constructive decisions about how to eradicate those things that are coming out. In industry, it is quality assurance, which is a normal thing; you get rid of the issue as quickly as you can and you improve as a result of it. So, I think that that is there.

[35] Inside the system itself, you have irregularity. So, across the health boards, you have irregularity, which is highlighted in the report—I bring you back to the report and to the figures that were provided to for me in this report, and you can see that there is not a consistent performance across the health boards. So, inside the 'Putting things Right' system, who is regulating on a national Wales basis? Is having 60% answering letters in 30 days good enough, or if we top 80%, is that better? However, actually, there is nobody above 95%. So, the goals are not being hit. Who is regulating the goals inside the system? Who is making sure that the teams are trained properly? You know, that regulation can take place, first of all, with a regulator inside. Outside of that, I think that you have the public services ombudsman. His office should be strong enough to make a further decision on a national basis, outside of that. However, for complaints, you need—. You know, if it cannot be improved by bringing more out at the board level, you have to have a regulator.

[36] **Darren Millar:** However, if a board is not doing its job in terms of analysing those data and changing things on the ground so that patients have a better experience, surely it is the Welsh Government's responsibility to hold that board's feet to the fire in terms of the complaints that are being received. There ought to be, somewhere in the system, some trigger points at which the Welsh Government itself intervenes and says, 'Sorry, as a board, you're not doing your job, you're not making changes, you're not learning from these mistakes, you've got too many serious untoward incidents and you've got too many patient safety incidents.' When you have a board with 12,000-odd patient safety incidents a year, as some of the boards have according to the figures in your report, something has to give, has it not? They are not learning from their mistakes. So, how and from where does that trigger point come? Some people have suggested that complaints and information and data on complaints ought to be a trigger for reviews and inquiries within hospitals in order to ensure that these things are being addressed. Do you think that that sort of mechanism is an appropriate one? At what level would you set these thresholds?

[37] **Mr Evans:** Just to cover a couple of the points that you have made, whatever Government is in power is of course responsible, on behalf of the taxpayers and users of the NHS, for making sure that the NHS is administered correctly. As politicians, you should be held to task, via the ballot box, if it is not. That is my view. So, that is the political bit to one side.

[38] Running the business or the hospital in a businesslike manner, to make sure that you are taking in all of the information that is coming in, and making changes are key elements that should be on the desk of every chief executive. Now, I do not know who appoints chief executives, but, certainly, when I was a chief executive, I knew who appointed me and that, at the end of the day, the responsibility was for the users and shareholders. So, of course, if you did not perform, you did not stay. In terms of where you put that in terms of level, you have to get the data and analyse them and if the data are not working, it is the role of the health board to investigate why it is not happening and to report that to the Government, if it is in charge, and to get a strategy in place to put it right. In terms of the general public, if that cannot be done, as an individual I would prefer that it was regulated, because I could not go anywhere else. I cannot say, 'I'm not going to have those staff anymore'. This is a monopoly—the NHS—and if you are ill or not, you are in it; you cannot help that. So, we want to have the best possible professional treatment in all parts of the NHS, including in the manner that it is handling and investigating its complaints process.

[39] **Darren Millar:** However, you do not think that there ought to be a system whereby there should be a trigger for Welsh Government or regulated intervention—

[40] **Mr Evans:** No, I do think that. That is in here—it is clearly in my report that it needs regulating.

[41] **Darren Millar:** Okay. So, in terms of—

[42] **Mr Evans:** I do not know what you want me to say, Mr Millar, but I am telling you that, in here, bringing you back to the report—

[43] **Darren Millar:** I am not asking you to say anything. I am just asking you whether there is a clear trigger point that, in your opinion, would require intervention. If so, what would that trigger point be?

[44] **Mr Evans:** Let me put it this way: if you could change the culture and make an open culture, I think that you would see more incidents than this. I think that you could benefit from seeing more incidents than this—more people speaking out and telling the truth about what is going on in their hospitals. So, that would mean that you would have more incidents. I know that they can be of a serious nature anywhere, but incidents, to me, mean people trying to help you to understand what is going wrong. So, you should be grabbing hold of that as a board and you should be analysing it and putting that right so that it does not happen again. Repetitive incidents become systematic—setting the level. So, you could say that you are going to have 20,000 incidents a year, so then you get 20,000 incidents. However, I would like to know, if there are 40,000, what the 20,000 are. So, creating the culture that can allow people to speak openly about what they are concerned about, whether they are employed or are a patient, is paramount to change. This culture change needs to happen in the NHS. It is quite strange to me, coming from industry, to have this type of lockdown with people.

[45] **David Rees:** Thank you for that. We have to move on because I am conscious of the time. Leighton is next.

[46] **Leighton Andrews:** If I can make a commercial comparison for a second, I have

done some analysis of the complaints that my office has handled over recent years and they range from what you might describe as 'poor customer service' to a more limited number of serious operational failings. Now, if you were to look at, for example, a complex utility like an energy company, you might have a regulator, but you might have different levels of consumer input, for example you might have a consumer council or something. There are a whole series of ways of handling those kinds of things. Do you think that there is a danger that, if we focus simply on the most serious nature of complaints, that lockdown culture is reinforced when actually what you want, if you are going to build a culture of openness, is to recognise the fact that, from the customer service end, there are simple processes that need to be addressed in order to facilitate complaints handling right the way through to those complaints, which may require a more severe regulatory engagement?

[47] **Mr Evans:** You can have a person in hospital who has not had a drink of water and that could be because they have drunk it or because the glass has not been filled. So, someone then fills the glass, apologises and says, 'I'm very sorry; I've now filled your glass. Is everything okay?' Through the incident reporting mechanism, if it is set up properly, if there were 2,000 people with empty glasses, you know that you have a problem with your water-filling system. That should be analysed and put right. This is where the small incident trend can become a major issue in any system, if you do not analyse it properly.

[48] In terms of the complaint mechanism, I am sad to say that I have been witness to some very sad stories through this review and I was quite emotionally touched by some of them, to be honest, and it is sad that this is happening. Complaints need to be treated in a manner where they are investigated properly. What most people have said to me is that they want a quality investigation done on what the cause was and that they would like to see from that a change taking place so that it does not happen to anyone else. People are quite right in their mindset to say, 'This happened to me—I'm telling you about it and I'm telling you because I don't want it to happen to another person'. That is a humanistic way in which people want to see the NHS move forward.

[49] **Leighton Andrews:** My impression from the complaints sent to me is that the bulk of them are actually about GPs rather than about hospitals. Do you have any thoughts about complaints handling around a range of independent contractors?

[50] **Mr Evans:** Again, I bring you back to the review. I say in the review that the manner in which GPs run independent businesses is not covered well enough within the scope of this scheme. That needs work done on it; it needs to be addressed and GPs and dentists and all of the contracted base need to become part of the complaints process correctly.

09:45

[51] I would even go outside that again, because quite a few people have mentioned social services to me. So, when you are trying to work across a lot of these different areas, you know, there are different complaints mechanisms and different ideologies in place for how your complaint works. So, there is that part, as I say in the report, which could do with further work.

[52] **Leighton Andrews:** My final point on this is that, even in commercial settings, you can see a situation where the people who are involved in the handling of complaints are seen by the operational managers as 'that group over there' who are designed to bring down hellfire upon them, as it were, and there is a disconnect sometimes within organisations. That happens within industry as much as it happens within the public sector, I am sure. Do you have views on how that can be managed?

[53] **Mr Evans:** Yes. I think that this is part of the cultural change. Wherever I went in my

previous career, I moved the people handling incidents, complaints and concerns to outside my office, because I wanted to be part of that team. Next to your front-line business, that is where the information is really feeding itself back into your organisation. Every fortnight, I would be happy to sit down and read the letters and correspondence that had come in from customers to be able to analyse them with the team and for me to be a part of the team that was leading the complaints process. If you alienate yourself from that, you can be kidding yourself about what is going on in reality in your organisation. That is my view; that is what I have tried to put in here. That is part of the culture change that we need to have in the NHS, and that, I think, can be achieved. It is all within the gift of the NHS; we are not asking for hundreds of millions to be spent, but it needs leadership. It needs to be led, and it needs to give the staff and the members the confidence that they can serve and look after their patients properly, and, if there is an incident or something happens, they can manage it and have it spoken about and analysed. That is for smaller incidents and, I think, especially for major incidents. The way that major incidents need to be analysed properly, with quality, to go back to the people who have been the subject of that with a proper, quality analysis that is open and honest, is part of the responsibility of boards in what they should be providing for the users of the NHS.

[54] **David Rees:** Okay, thank you. Andrew is next.

[55] **Andrew R.T. Davies:** Thank you, Chair, and thank you, Mr Evans, for your report. As someone who has the scars on his back from the NHS Redress (Wales) Measure 2008 that went through the last Assembly, when I was sitting in a committee at 8.30 a.m. taking evidence that this NHS redress Measure was going to be the eureka piece of legislation that was going to get on top of a lot of these complaints and do what it says in the title, namely seek redress for patients, much of what you have said I can recall being said back then, some five or six years ago, about an open and transparent culture in particular and needing to respond to the complaints in a timely manner, and everyone would agree with that. My point to you, however, is this: do you seriously believe that, as the boards are constructed at the moment—at board level, I am talking about, and executive level—they are capable of actually implementing much of what you have found in your report?

[56] **Mr Evans:** Yes. I just think that where the difficulty came was that, in the applying of this new legislation and the reorganisation of the health boards, in some cases, the risk that the ‘Putting Things Right’ legislation has placed on a hospital board has not been realised, and they need to reassess that. They need to reassess it, they need to get their prioritisation of it right, and they need to make sure that it is supported properly in its infrastructure. I do not think that you need to spend another three years rewriting legislation that was only written three years ago by many people who came from many walks of life to make this legislation to make the NHS better. However, I think that a serious look needs to be taken at its application, because it has not been resourced properly, and, as a result of that, it is the patients and complainants who suffer.

[57] **Andrew R.T. Davies:** My point is—and many Members around the table today have talked about their experiences in private business—that, actually, the NHS cannot be compared, I would suggest, because of the political pressures. You can bring some of the processes in, but it cannot be compared, because of the political pressures, the obligation, and the monopoly structure that it finds itself in, especially from a staff point of view. Many staff fear speaking out, because, obviously, if they do lose their job, there is not really much of an alternative for them to go to to practise elsewhere, is there?

[58] So, you have talked at length about the breakdown between ward and executive function—in particular, a reflection on the chief executive, I think you said, over the ability to make the changes and implement measures to address the complaints. Again, this is language that I heard five years ago. What specific measures would you suggest need to be

implemented? The sentiment is correct in saying that that breakdown should not happen, and that the executive should take control, but we know that it has broken down. So, what specific measures would you say would actually reinvigorate the system and reinvigorate that responsibility at executive level and, importantly, at chief executive level, so that they take ownership?

[59] **Mr Evans:** Well, there are more than 100 here, in my report.

[60] **Andrew R.T. Davies:** I appreciate that, but the recommendations that we have had in all our reports five years ago were saying much the same. You talk of the regulator, for example, being empowered to order best practice into health boards and trusts. So, what empowerment would you suggest? The Minister has that at the moment—the Minister can direct and instruct—

[61] **Mr Evans:** Then he should set it.

[62] **Andrew R.T. Davies:** So, it is a failure of the Ministers over recent years?

[63] **Mr Evans:** I am not answering that question. I do not know whether it is the failure of the Minister. So, let us come back to this report, which is about the complaints mechanism, about putting things right. It is quite in-depth, it is a top-to-bottom report on that mechanism, and it has more than 100 recommendations. I would suggest that if any health board—even if they are doing this, because some of them are minor, but I have put them in because they are not happening in reality—uses this list as a checklist, it will be on its way to having a better complaints process.

[64] There are serious recommendations in here as well, which need to be taken up by boards to make sure that they are providing the proper complaints service. At all times during this review, I have stated that you cannot compare the NHS to industry. I have said that it is a monopoly. Even if you can afford private medicine, if you have the misfortune of having an accident somewhere, you are in this system. So, proper regulation by all people—that is the responsibility, from the Minister right the way down—to make sure that users are having the proper, professional service that we would expect from the NHS, is paramount.

[65] **Andrew R.T. Davies:** May I just ask one question?

[66] **David Rees:** Well, we only have a short time, and I have Kirsty and Elin to come in. Kirsty is next.

[67] **Kirsty Williams:** One of the themes throughout the report—and other people have brought up the complaints system—is the capability of the complaints team to be able to offer a service. Inevitably, in a system that involves human beings, mistakes will happen and complaints will arise, but how you deal with that complaint can either help solve the problems or compound the hurt and the harm and the distress felt by those involved. You talk about a lack of resourcing going into complaints teams. Is financial resourcing the only barrier that you have identified in those teams, or what else could we do to ensure that we have the right level of expertise and capacity within an organisation to handle complaints well?

[68] Secondly, you have spent a lot of time talking about the accountability of the board, the chief executive and the chair. In my experience, the nastiest letters that I have ever seen issued to chairmen and chief executives of boards from Ministers are about the requirement to balance your books at the end of the financial year. Do you think that there has been sufficient weight attached to performance in the field of complaints, as opposed to performance in the field of financial management and hitting clinical targets? Do you feel that we need to make it more explicit, from the centre, to boards that they will indeed not just be held to account for

clinical waiting list targets and financial propriety, but that actually this is something they will be relentlessly quizzed on by Ministers or directors of NHS Wales?

[69] **Mr Evans:** The answer to that is that I think that the profile of complaints management is not high enough and it is not being challenged enough. It is not part of the routine inspection of what is going on in the running of a health board. I recognise that and think that this whole thing should be up with the profit and loss and the balance sheet management; you need to put this up at the same level so that it is reviewed constantly. Incidents, concerns, and complaints, if you do not manage them properly, can become systematic, systemic, major failures over a period of time. So, I think that the profile of this needs to be much higher up in the board. It should be part of the report pack to whoever the Minister is, whoever is in Government—it should be part of the report pack.

[70] **Kirsty Williams:** What about the barriers to successful complaints handling within each organisation? You talk about a lack of financial investment, but is that the only barrier? Is it just about money?

[71] **Mr Evans:** What I have noticed about the complaints handling teams is that they are teams that are really stretched. They are stressed, they are working long hours, and they are handling extremely difficult topics and subjects in the complaints arena. In some of the meetings, they have been quite emotional—because I do not work for the NHS, there has been a lot of outpouring about this. You have experienced people working in them who tend to be quite deluged. You have younger people trying to handle people who are bereaved who may not have experienced bereavement themselves, even with their parents and things like that. So, I think to put the team together properly in that handling team, your chief executive needs to be in it and your complaints handling director, you need your nursing director, you need clinical people and some legal people, and they need to be able to know how to communicate. Communication is not easy; it is not a natural gift for a lot of people. You need to make sure that people can communicate in a compassionate manner. We are dealing, in the complaints arena, with people who have suffered trauma or who have suffered bereavement and are finding it difficult, even with the more simple complaints system, to come to terms with making the complaint. So, I would think that what I have just mentioned would be quite a high and important level of investment to be made into that part of the organisation to manage the complaints down. There are good examples of that; I think you will be speaking to some people later this morning who have done that and who have, in fact, through that type of concept, managed down quite a considerable amount of complaints to get it under control.

[72] **David Rees:** Okay, thank you. I have Elin next, with the last question this morning.

[73] **Elin Jones:** I just want to say that the number of complaints per local health board has increased quite dramatically over the last four years. That could be a good thing, because more people are empowered to complain, or a bad thing in terms of there being more to complain about. However, those data are only available via freedom of information requests. Do you think that there is a case for a public log of complaints? That would aid with—it would certainly help with transparency—perhaps lifting it up the agenda of board members and making them more aware of their public accountability on this and also work to help the culture change that you have talked about.

[74] Secondly, quickly, a lot of your work and a lot of our discussion this morning has been about formal complaints. Very often, before a complaint is formally lodged with a local health board, there are lots of informal complaints that happen at ward level, for example. I think that you suggest in your report that customer care training could be part of improving the method of dealing with informal complaints within the health board.

10:00

[75] I am not sure whether I have understood that correctly. I would like to see that it is not just about the formal complaints, but about using informal complaints, and improving the way of dealing with informal complaints, to reduce the number of formal complaints that eventually end up in the system.

[76] **Mr Evans:** Yes, I agree with those comments as well. If you can prevent an informal complaint becoming formal, by communicating correctly, that is great, but then it is an incident, because something has happened that has made somebody feel that they need to start making an informal complaint. There should be a mechanism for logging that, because it is these constant little small things that lead to the big catastrophic disasters. So, there needs to be a mechanism for a complaint to be able to be registered or made at any level. That is my view.

[77] In terms of us as members of the public being able to see what the complaints levels and numbers are, I think it would be good if that was the case, providing that you are respecting people's personal data and things like that. For us to be able to see how a health board is performing in terms of all of its aspects should be important. Health boards have open board meetings, so there is a place where they could be debated. We also need proper national figure gathering, because I did find it a bit difficult to track some of the figures down. It is important to have data, because that is where you can see your trends. You need to have quality data so that you can see what trend is happening. If that was shared with the public, it would help to make the NHS more open, it would be less defensive about its complaints process and it would not be in shock and awe every time something happened as a result of a complaint. In doing it that way, you would be able to benefit from using the information that was in the complaints process to improve for the users of the NHS. This, to me, would be fundamental patient care. Basically, that would be part of the fundamental patient care.

[78] Complaints go up and down. If you have long waiting lists, you will have an increase in complaints. So, if you can reduce the waiting list, they will go down. Where you need to be focused is on the repetitive, continuous incidents that give you signals that something else might be wrong in the organisation. In particular, you need to get senior management involved as quickly as possible in serious incidents and complaints.

[79] **David Rees:** Okay, thank you. I am conscious of the time. Ann can have the last question, since I sit on her committee and I often want the last question. [*Laughter*.]

[80] **Ann Jones:** Thanks from me, Chair. The report is very clearly written and it is very good. It has 109 recommendations. What one single recommendation would you say is the most important that would have maximum impact on getting the complaints process right?

[81] **Mr Evans:** I feel that if we cannot get to a situation where boards can manage the boards correctly on this, then you need to have a regulator. That is very important. Creating the culture change is the second most important thing for me. You feel, when you speak to people, that you are in a rather locked-down culture. Staff say that it is easy to speak, but actually it is not, otherwise you would not have as many whistleblowing-type activities—not only national ones, but local ones—going on in the health boards. For me, it is a long-term job. It is about the culture change of the organisation, to make it open and honest about what goes on and not to be defensive about hiding things. As a society, we have to also understand that you are fighting disease and illness. It moves on all the time. It changes. You are going to have mistakes that have to be analysed properly, looked at and overcome.

[82] **David Rees:** There is just a final question from me. Culture change is the biggest issue that you have talked about. In your experience of the industry, as you have already said, it is a long-term agenda. What type of timescales are they? This is an important aspect,

because we might change things at board level now, but people may not feel that change initially and therefore may still have that fear. What type of timescales do you have experience of as to how long this takes?

[83] **Mr Evans:** Nothing lasts forever anywhere, so I think that anyone who has come from a similar background to mine will know that the time that things last for in this day and age gets less. In my previous experience, we would be trying to work 20 years out. So, where would we want to be in 20 years? That would be brought back to where we would want to be in 10 years, five years and three years to make sure that you could get—. That strategic type of planning does need to be in place, otherwise, as Mr Davies was saying, you sit down around the table hearing the same things being spoken about. You have to bear that in mind. I was interested to read some of the commentary that came from the people in the wards, in the *Nursing Times*, and they were saying, 'This is no "what's it" Sherlock territory again', because, in other words, they have heard it all before, with comments such as, 'I could have written a report like this because a sharp-end nurse knows what is going on'. So, there is a culture of bringing things in that are not being absolutely driven through. Strategic planning for that needs to be strengthened. It is long term. To turn a major corporation round can take five or 10 years. To do the same here, I would imagine that it is going to be a long job.

[84] **David Rees:** Thank you very much for that, and thank you very much for your evidence this morning, which has been very helpful to us. You will receive a copy of the transcript to check for any factual inaccuracies or errors that you identify. Please let us know if there are any. Thank you very much.

10:08

Ymchwiliad i Broses Gwyno'r GIG: Sesiwn Dystiolaeth 2
Inquiry into the NHS Complaints Process: Evidence Session 2

[85] **David Rees:** Good morning. I apologise for the slight delay. I can assure you that you will have the full time allocated to the session.

[86] **Ms Clwyd:** We have been well looked after out there.

[87] **David Rees:** I welcome the Right Honourable Ann Clwyd MP, who was co-chair of the review of the NHS hospitals complaints system in England, which she was asked to undertake by the Prime Minister and which reported back to the Westminster Parliament. Thank you for your written paper to the committee as well, which highlighted some of the points from the report by Keith Evans. We would like to go into some questions now, focusing upon comments by the witness in that statement, but also on the work that you undertook for the English review. We will start with Gwyn Price.

[88] **Gwyn R. Price:** Good morning. Keith Evans describes complaints as 'a gift' to the NHS. How do you see that? Do you see complaints coming in as a gift so that we can use the analysis?

[89] **Ms Clwyd:** In my own report, I use the words 'gold dust'. I think that that is what complaints are, because they are worth treasuring and informing and, hopefully, acting on. So, I totally agree with his description. I used a similar one.

[90] **Gwyn R. Price:** Thank you.

[91] **Lindsay Whittle:** Good morning. I notice in Hansard—the Record of Proceedings in Parliament—that you have said that if the Welsh Assembly requests the Welsh letters, you would hand them over. Have you already done that?

[92] **Ms Clwyd:** We all know about data protection now and what that means. The letters were written to me, and whenever I referred to any letters in Parliament, I telephoned the people involved, and at no stage did I mention their names, their addresses or the hospitals that they were complaining about. Obviously, I passed on some of those letters to Mr Evans at his request, but I asked the people concerned each time if that could be done. I would have liked to have handed them all over, but, as you can imagine, just ringing up people up and asking their permission takes a lot of time and we did not have the resources to do that.

[93] **Lindsay Whittle:** You did say, and it is a matter of record, that you are concerned about the number of letters that you have had from Wales, but given that you had an understanding from the Welsh Government that they would be treated confidentially, you would be pleased to hand those letters over. So, how many letters did you hand over?

[94] **Ms Clwyd:** I cannot answer that. I think that Mr Evans could probably answer that, but quite a number.

[95] **Lindsay Whittle:** Quite a number.

[96] **Ms Clwyd:** Yes. Let me tell you about the amount of letters that I am talking about. By now, I should say, because they are still coming, that I have had 4,000 letters and e-mails. I have not added up the telephone calls, but people in my office—and there are only two working in my office in London—have to deal with people's telephone calls still, and we always ask them, 'Have you spoken to your Assembly Member? Have you spoken to your MP? Can we pass on your complaint to them?' Obviously, each MP is responsible for their own constituency and not for other people's. However, they are still coming in and people cannot understand when you say to them, 'I can't deal with yours because you're not in my own constituency'. All the politicians will understand that, I am sure.

[97] **Lindsay Whittle:** Yes. Your review had lots of conclusions and lots of recommendations. I do not think that many people would argue with most of them, but in your review into the English health service, was the volume of complaints about the Welsh health service clouded by the volume of complaints about the English health service?

[98] **Ms Clwyd:** The content was more or less the same. Wherever you had letters from people, whether it was England, Scotland, Wales or Northern Ireland, basically, they were saying the same things, so there was no difference in the type of complaint that they were making. So, that is what struck you first of all: the similarity between them all, unfortunately.

[99] **Lindsay Whittle:** So, the 4,000 complaints that you have had about the Welsh service—

[100] **Ms Clwyd:** No, no, I was talking about the total number that I have had. I would say that, of the total, about 20% involved the Welsh health service. Obviously, being a Welsh MP, they thought that I was doing a complaints review, but they had not understood that it was England only. The people who wrote in still wanted to send their complaint to you, phone you up or make a point to you and ask you to act. So, about 20% of the total was from Wales.

[101] **Lindsay Whittle:** Okay, thank you for that. My final question, Chair, is quite simple really. During your conclusions and your recommendations—as I have said, there is no argument with most of them—did you visit any hospitals to come to those conclusions and recommendations? Your final recommendation, and it is the only time that I see the word, is that trusts should be actively encouraged to have both positive and negative feedback. There is a lot of good work in the Welsh NHS as well, and I am sure that there are lots of members of staff in the Welsh NHS who are quite upset at all of this criticism all the time. If the

criticism is justified, I fully understand that and complaints should be treated seriously; we have heard evidence prior to your coming here today on how we are going to try to address that. However, there is just the one use of the word 'positive'. If you visited hospitals, you will have seen on wards, left, right and centre, 'thank you' cards bedecking the walls. I think, sometimes, that we should look at both sides of the argument as well. However, that is not taking away anything from the seriousness of people's complaints about the service in the NHS.

10:15

[102] **Ms Clwyd:** If you have seen a copy of my report, you will know that there is an annex at the back that lists the hospitals—in England, as I did not visit hospitals in Wales—where there are good practices and bad practices. Of course, a lot of good work is done in the NHS, and nobody wants to take away from that. However, where there are complaints about the NHS, then they have to be taken seriously.

[103] **Lindsay Whittle:** Yes, of course.

[104] **Ms Clwyd:** However, I did not visit any hospitals in Wales as that was not within my remit.

[105] **Lindsay Whittle:** I see.

[106] **Ms Clwyd:** However, being a Welsh MP, informally, I do visit people in hospital in Wales.

[107] **Lindsay Whittle:** Your answers have been very enlightening; thank you.

[108] **Lynne Neagle:** Thanks for your paper, Ann. I wanted to ask first about the issue of support for patients who are making a complaint, because you have highlighted some concerns about the level of support that is available. I specifically wanted to ask about community health councils because you will obviously have seen a difference there because they do not operate in England, but we have retained them in Wales. How effective do you think they have been and are there any changes that you would recommend to the support provided by CHCs in Wales?

[109] **Ms Clwyd:** I have not studied CHCs in Wales. I know about the CHC in my own electoral area, and I know that they vary a lot. As a former member of a CHC in the 1970s, which was the Cardiff CHC, I know how we operated then and how variable the operation is now. CHCs need to be trained properly, the leadership of CHCs needs to be strengthened, and there should not be such variability between areas. I would say that, because they are not operating in England, as you know, CHCs need looking at again and they need to be properly resourced, and by 'resourced', I mean training for the chair of the CHC and the people who are members of the CHC. In the same way, I would argue that the membership of hospital boards also needs to be properly trained. CHCs obviously have an important role to play, but, if I can generalise, at the moment I do not think that they are playing it.

[110] **Lynne Neagle:** Okay. Are there any lessons from England in terms of the support that it offers to patients making complaints that we could learn from in Wales?

[111] **Ms Clwyd:** Well, it was in October last year that I came out with my review. We tried to hard-wire into the recommendations follow-ups to make sure that it was not just another set of recommendations that sat on a shelf somewhere, and everybody said when the report came out, 'Good report; very good recommendations', but then nothing happens. In England, we have the chief inspector of hospitals, Sir Mike Richards, who was on the radio

this morning, because he is going to be looking at care homes as well. He has been charged with making sure that our recommendations are implemented. He visits a lot of hospitals in England, and we meet him every three months to find out what has happened. I have been on too many committees where things just gather dust. I was very sure that, with this one, we had to hard-wire into the system follow-up action to the recommendations.

[112] **Lynne Neagle:** Okay, thanks. Just on the issue of independence, which you have highlighted in your paper, you have taken evidence from patients who are concerned about the independence of our system in Wales, which of course changed a couple of years ago when we took away the independent review stage. You have said that you support the idea of an independent complaints regulator as put forward by our previous witness. Is that sufficient and do you think that that will deal with the concerns about independence if we put that in place?

[113] **Ms Clwyd:** I think so. I think it is a start. I read Mr Evans's paper, and I support that particular recommendation of his. I support a lot of others as well, but that particular one is an important one because of the absence of what people look at as being an independent regulator. Ideally, I think that it should be someone who is not connected with anybody or anything, if that is possible—to be truly independent.

[114] **David Rees:** May I expand on that a little? Mr Evans highlighted the fact that that should be the HIW. Is it your view that HIW could take on that role?

[115] **Ms Clwyd:** Sorry, could you repeat that?

[116] **David Rees:** Mr Evans indicated in his review that HIW should take on that role. Do you believe that HIW could take on that role as the independent regulator?

[117] **Ms Clwyd:** I cannot answer that. I know what has been said about HIW and I know what it has said itself—that it did not have sufficient resources to be an effective inspectorate in Wales. I know that you are looking at that at the moment and that HIW, I believe, is going to be beefed up. However, in the absence of a beefed-up HIW, then I think that getting the independent regulator in place quickly is a very good signal to people.

[118] **David Rees:** Okay, thank you. Darren, you are next.

[119] **Darren Millar:** Thank you, Chair. Your work on complaints, Ann, has caused you to speak out and raise concerns about the national health service in Wales and, as a result of that, you have been accused by some of your Labour Party colleagues of denigrating the entire Welsh NHS without data and evidence to back that up. The First Minister has even said that you have produced no evidence and no facts. How do you respond to that?

[120] **Ms Clwyd:** I think that I have already responded to that in the past. My report is here. It was England-based, but, because of the letters that I had from Wales and also as a Welsh MP, I realise that there are problems in the health service in Wales. I spoke out about them and tried to flag them up. I think that you know what my particular issues were—mortality rates and the long time that people have to wait for diagnosis. Those are things that I will continue to talk about, but not now.

[121] **David Rees:** Do you mind focusing on the complaints process?

[122] **Darren Millar:** Yes, absolutely, Chair, but I think that it is important to get this information on the record. The complaints were one of the pillars of information that you suggested need to be used to inform the Welsh NHS of how it is performing. You have mentioned some of the others that you have just referred to, but you have drawn analogies

between not learning from complaints in Mid Staffordshire and the potential for Wales to have a catastrophic failure if it does not learn from complaints here. Do you think that there is a trigger point that ought to cause an intervention—a sort of Francis-style or Keogh-style review—in a hospital when complaints of a certain nature or of a certain volume are coming through the system?

[123] **Ms Clwyd:** I think that if there are problems in certain areas, it is a good thing to get somebody in from outside to have a look at them. Quite often, because you live with them, you may not be as objective as you might be. I think that everybody learnt from Francis, and from what has come after Francis, and we must act on the conclusions of Francis—I read through them occasionally—because the points that he makes are quite horrifying. We know, for instance from the ombudsman's report in Wales, that some of those things are still happening. You cannot believe it, when you look at the ombudsman's report that I have attached to my statement. I think that the most telling, recent evidence of the failure to learn from complaints is to be seen in the report of the Welsh ombudsman. For example, the 11% increase in the number of complaints against NHS boards and trusts in the last year is something that should be taken very seriously. On some of the points that the ombudsman makes in her report, you cannot believe, when you look at some of the individual hospitals, that the ombudsman recommended that the health board should,

[124] 'remind the relevant staff of the importance of good record keeping…remind all staff of the need to ensure that patient's fluid levels are adequately monitored; provide refresher training for the relevant staff on dehydration and when to initiate fluid monitoring; ensure adequate blankets are available to all patients within the First Hospital'.

[125] I could go on through the boards, but they reflect, I think, some of the points that were made to me by individuals, in letters and in conversations that I had with people. The things that people complain about most frequently are things that could be put right at the bedside and they need not escalate into something bigger. They are complaints that could be put right at the bedside, such as there not being enough blankets, somebody feeling cold or not having enough pillows and people who are not being helped to drink or eat, because they cannot do it on their own. The fact that the ombudsman is now saying this to some of the health boards, it seems to me, demonstrates that comments that have been made before have not been acted on.

[126] **Darren Millar:** In spite of the suggestions about the evidence base on which you have drawn and made your assertions, you have indicated this morning that, in percentage terms, around 20% of the 4,000—about 800—complaints have been made about Wales. Actually, your findings in the paper that you have submitted to the committee are very similar, it has to be said, to the findings that Keith Evans cited in his report. So, it is surprising that they have been challenged.

[127] However, one of the key recommendations in your report was in respect of a duty of candour in England, and, of course, the UK Government is in the process of making sure that that is something that will have to be regarded in the NHS there. There are powers available, of course, to Welsh Ministers to implement a duty of candour here in the Welsh NHS, but they have chosen so far not to do so. Is that something that you would like to suggest that Welsh Ministers pick up, as well?

[128] **Ms Clwyd:** Well, you just hope that everybody who works in the health service is going to be honest. You know, if they see something that is wrong, they can tell somebody that it is wrong. What I am concerned about is the fear that so many people have about speaking out. The staff are afraid, the patients are afraid and the patients' relatives are afraid. That just cannot be right. I think, in Wales, there is a tendency not to complain as much as people ought to complain when something is wrong. There is a tendency to feel, 'Oh well, we

don't want to upset anybody, and we don't want to bother them'. There is also the fear that it will be taken out on them in some way if they do complain—you know, that they will get poorer treatment, or that their relative in the bed will get poorer treatment. So, the fear is all around. I think the honesty must apply in all cases. I think that chief executives and chairs of boards ought to encourage that honesty—it is absolutely essential. Whatever you call it, people should be able to speak out if they think something is wrong.

[129] **David Rees:** Okay. Ann is next.

[130] **Ann Jones:** Thanks. Ann, I want to carry on about the ombudsman and I notice that, in the appendix to your paper, you recommend what the seven health boards should do. I wondered how many of those bullet points that you have listed just relate to one case. There are a number of bullet points there, but if there was one serious failing—and one serious failing is one too many—within a health board area, the ombudsman might recommend 10 points. Yet, if I just take my own area as an example, there are 19 bullet points that the ombudsman has recommended for the health board. How many cases would that have involved? How many of these are bullet points that appertain to one serious case? Does every ombudsman's report contain all of the bullet points that you have listed?

[131] **Ms Clwyd:** You have the ombudsman's report. I have questioned the English ombudsman, but I have not questioned the Welsh ombudsman. I think that the main points in many of these board areas are so similar to the ones that I had in England that you get the feeling that it is almost common practice.

10:30

[132] We know that dehydration is a problem. We know that people say that they need help to eat and they do not get it. We know of people who are left to soil their beds and to lie on soiled sheets because there is no-one there to help them. There are not enough people around or people say, 'We'll come back later'. We all know these cases. Particularly as Assembly Members and Members of Parliament, we know that this is commonplace, I am afraid. You can describe them as bullet points, but I think that they are bullet points that are very common throughout the service.

[133] **Ann Jones:** Yes, but if there was one serious failing that the ombudsman looked at—as I said, one serious failing is one too many—and all of the 19 bullet points that you have listed for one particular health board here referred to that one case—. It may have been one serious failing case, as opposed to 799 other cases that you say happened, or about which people contacted you, in the Welsh NHS. What I am trying to understand from the evidence is—. I hear what you say about the commonplace things, such as not enough blankets or pillows, which you say could be addressed at the bedside; I think that most families do address those at the bedside. I do not think that there is a big issue of complaint there. I certainly addressed all of those issues when I had a case of a relative in hospital. I addressed those at the time, and they were dealt with. I am just trying to work out, with the very serious ones, whether the 19 bullet points are for one serious case or whether there were several ombudsman reports, with each one coming out with a different failing. That is more—. It is bad enough that you have these failings. I just wanted to know whether it is a case of serious failings or just a mismatch of a lot of lesser failings, which are still failings to people, but nevertheless—

[134] **Ms Clwyd:** I think that you need the ombudsman here, actually, to answer that question.

[135] **David Rees:** I think that the question relates to these, I assume, being examples of reports and therefore not totally complete, but some examples that you have picked up from

the various reports.

[136] **Ms Clwyd:** Yes, but I think that they are common examples, I am sorry to say.

[137] **David Rees:** That is why I wanted to ask the question.

[138] **Ms Clwyd:** There is poor record-keeping.

[139] **David Rees:** From your experience in England, because you have said that you have met the ombudsman in England, have you found repetitive comments coming from the ombudsman there? On some of the cases that you dealt with, there was so much commonality that you were getting similar comments across different boards. As a consequence, what learning was actually gained from that?

[140] **Ms Clwyd:** I must say, having looked at the Welsh ombudsman's report, that I did not see those kinds of things coming up with the English ombudsman. One of the reasons is that she looked at so few cases. That was one of the criticisms that we made in the report. She looked at so few cases. However, some of these should not have had to go to the ombudsman. That is the point that I am trying to make. They should have been addressed by the chief executive, the chair, the board, or all of them. Senior management should have addressed some of these commonplace problems.

[141] Another one that I should mention, and I suppose that people criticise nursing because it is the nurses that they mainly see, it that there was a lot of criticism of nurses' stations. Everyone will know what a nurses' station is: it is where nurses tend to cluster. Relatives and patients almost feel that they are intruding there. We have lots of quotes in my report about nurses' stations. There is a comment about a relative asking a nurse for help and going to the nurses' station, where they were all doing eBay and turning to them and saying, 'Well, when we have finished this, we'll come to you'. That may be an extreme example, but I think that it is indicative of how people feel about things like nurses' stations. A lot of people who wrote to me want to see them scrapped. Certainly, older nurses criticise things like nurse training and say, 'It isn't as it used to be', but I suppose that we all say that it is not as it used to be. They think that there should be more on the wards than anywhere else.

[142] Sharon has just passed me a very useful note, which I cannot read. [*Laughter*.] The ombudsman's recommendations are from several cases within a three-month period. I think that it is important that it is a three-month period, from January to March—it is not just one.

[143] **David Rees:** Is that okay, Ann?

[144] **Ann Jones:** Yes, fine. Thank you.

[145] **Andrew R.T. Davies:** Thank you, Ann, for coming in today and for giving your evidence. As I said to the previous witness, I sat on the committee that dealt with much of this before. We were given assurances that the complaints procedure would be simplified by the NHS Redress (Wales) Measure 2008, because it was all about taking the litigation out of the process and dealing with the complaint at source. Given your understanding of what you have dealt with—you have had 800-odd complaints from Wales out of 4,000 in total; you have had the luxury, I would suggest, of having been able to look across the whole of the United Kingdom—how have we arrived at where we are today? What is the key thing? Is it simply poor management? Is it a lack of direction? What is it? That is what most people ask: how have we arrived at this situation?

[146] **Ms Clwyd:** I feel that the buck should stop with the chief executive, the chair of the board and members of the board. I do say that management has a lot of responsibility for what

has been going wrong. I think that that needs to be addressed.

[147] I was on the Royal Commission on the National Health Service, which reported in 1979. For three years, we looked at hospitals across the UK, including hospitals in Wales, and we came out with our report, but there was a change of Government and the report gathered dust. That is why I am so conscious of the need to make sure that, whatever you recommend, it has to be implemented. People talk about morale. In 1977, people were saying that morale was low. Whatever group you talked to, they said that morale was low. I think that that sort of attitude continues. With any group of workers, if you ask, 'How are you feeling; how's morale?', they will say, 'Morale is low'. That is something that has been true over a long period of time.

[148] I was on the Welsh Hospital Board that ran the health service in Wales, from 1970 to 1974. When that was abolished, again by an incoming Government, I went on a community health council, which is how I know how CHCs worked then. Obviously, I have not had that sort of contact at close quarters with the health service in Wales since then, apart from being a constituency MP. I do not think that there is anything wrong that cannot be put right.

[149] **Andrew R.T. Davies:** Do you believe that the current boards, as constructed and in the way that they are appointed, can be put right, or do you believe that there needs to be change in the accountability of boards in their current configuration, and in particular in the appointment of the two senior positions, namely chair and chief executive?

[150] **Ms Clwyd:** I think that accountability and responsibility are very important, and I think that people who do go on boards, either as chairs or as members, should be trained. I looked at the minutes of a board recently, which are open to the public, and I think that they are incomprehensible. If they are meant to communicate to the public what is happening in that board area, then they have to be written in language that people understand. We do not all come from a management background and we are not used to that language. One of the things that I kept saying throughout my own report was, 'Let's have things in plain English'—or in plain Welsh, as the case may be.

[151] **Andrew R.T. Davies:** My final point is that Darren Millar questioned you on the duty of candour. We would all subscribe, we would hope, to the idea that people would be forthcoming with information and be open, honest and transparent. Sadly, we know that that is not the case. Do you believe that that duty of candour in a Welsh context should be formalised, as in England? Obviously, there is no formal duty placed on staff at the moment.

[152] **Ms Clwyd:** I think that that is for you, if I may say so—if I can toss it back in your direction. You are the elected Members with responsibility for the health service, and I think that you are the ones to come to that decision. I can only say that people should be encouraged to speak out; they should not be afraid of speaking out. I have to say that I have had a number of anonymous phone calls telling me about what is going on here or there from people working in health boards, as I understand it. They will not give their names. On several occasions, I have asked: 'Can you give me your name? Can you give me some clue as to where you are working?' and they say, 'If I tell you my name, I'll be sacked'. So, that is still there, the fear of speaking out. Somehow, we have to make sure that people feel free to be honest when they feel that there is something they are worried about. I say this throughout my own report.

[153] **Leighton Andrews:** May I ask you about the nature of the handling of complaints? You were talking, in a sense, at the beginning about the importance of seeing complaints as a learning process, if you like, and you said that they are a treasury for improvement. Is there not a danger, though, in the current climate, where people focus solely on the nature of complaints? I recognise that there is a very significant amount of very good work going on

within not just the hospital system but the health service as a whole.

[154] **Ms Clwyd:** Of course. I have always prefaced everything that I have said by saying that I recognise, as everybody else does, the very good work that is done in our national health service. However, at the same time, when there are things that we know are wrong, it is our responsibility to speak out about them and to try to get them put right. However, certainly, nothing I say should take away from my great admiration of the NHS and what it has achieved over the years. It has meant a lot to people in all the areas that we represent in particular that people respect and admire the NHS and the good work that is done within it. However, the people who are responsible for management—the chief executives, the chairs of boards—have a great responsibility. The people who work within the service that they are responsible for should be able to tell them, without fear of any kind of reprisal, what is wrong.

[155] **Leighton Andrews:** If we take the approach that complaints are part of the learning process, given that the NHS is treating more and more people and that it is treating a lot more older people with quite complex and often multiple conditions at one time, it is quite likely, is it not, that, within that, we are going to see a growth of complaints in some areas? Is that fair?

[156] **Ms Clwyd:** I think so, yes, as the population gets older, obviously, and has multiple problems. However, I think that that is why it is even more imperative that, if there are complaints about the treatment they are getting, people should be enabled to speak out. Elderly people are going to be even more frightened, I think, of making a complaint. Many people do not have relatives who can go into hospital with them and stay with them, so they need to feel certain that they are getting the best care possible and that they are not distressed in any way. When I first started getting these letters, I have to say, I read them all for the first month and then, like Keith Evans, I felt almost overwhelmed by them and the problems they raised. However, also, it has just made us more aware of the need to pin the responsibility where it belongs to get things right.

[157] **Leighton Andrews:** There has been a lot of focus on hospitals, but I have done an analysis of the complaints that have come through me as an Assembly Member over the last few years and my impression, actually, is that a lot of them are about customer service at a GP level. Do you have any observations on that?

[158] **Ms Clwyd:** Well, you see, I only looked at acute hospitals. That was my remit. I did not look outside acute hospitals, but I noticed, for instance, that Sir Mike Richards, the chief inspector of hospitals in England, has today said that they are going to extend the review work that they are doing into care homes.

10:45

[159] Obviously, as people get older, maybe more people will be going into care homes, and I think that it is good that they are doing that. I do not know whether you are doing the same in Wales—are you? It is something, I think, that needs to be looked at, as more elderly people go into care homes, to make sure that the quality of service and care is there, because they are even less likely to have people to speak out on their behalf.

[160] **Leighton Andrews:** I accept that, and that is clearly part of our role as advocates. Would you accept that, by and large, what is commonplace in the health service is that most people get good treatment?

[161] **Ms Clwyd:** Oh, yes, of course. I said that at the beginning—absolutely.

[162] **David Rees:** I have Elin, followed by Kirsty. I think that we are running short of time now.

[163] **Elin Jones:** Bore da. Gofynnaf yr un ddau gwestiwn i chi ag a ofynnais i Keith Evans y bore yma. Yn gyntaf, mae dau fath o gŵyn: mae cwyn ffurfiol, efallai yn dilyn gofal neu, o bosibl, farwolaeth unigolyn mewn ysbyty, ond, cyn hynny, gall fod nifer o gwynion anffurfiol ar ward yn ystod gofal unigolyn. Felly, mae sut mae rhywun yn ymdrin â'r cwynion anffurfiol ar ward yn bwysig, fel nad ydynt yn dod yn gŵyn ffurfiol a'r gofal yn broblematig a'r problemau yn cynyddu.

Elin Jones: Good morning. I will ask the same two questions that I asked Keith Evans this morning. First, there are two types of complaint: there is a formal complaint, perhaps following care or, possibly, the death of an individual in hospital, but, before that, there can be a number of informal complaints on a ward during an individual's care. So, how someone deals with the informal complaints on a ward is important, so that they do not become formal complaints with problematic care and increasing problems.

[164] Yn yr ateb a gefais gan Keith Evans, soniodd y byddai rhyw fath o *incident log* ar ward, lle byddai unrhyw gŵyn—er enghraifft, bod gwydraid o ddŵr heb ei roi i rywun—wastad yn cael ei chofnodi, fel bod patrymau dros gyfnod, wedyn, yn gallu cael eu gweld gan y rheolwyr a'r bwrdd. Nid wyf yn gwybod a oes gennych unrhyw sylwadau i'w gwneud ar sut mae gwella'r modd o ddelio â chwynion anffurfiol ar ward, a delio â nhw'n sydyn iawn, fel nad yw problemau'n cynyddu.

In the answer that I had from Keith Evans, he mentioned that there would be some sort of incident log on a ward, where any complaint—for example, if a glass of water had not been given to somebody—would always be recorded, so that patterns over a period of time could then be seen by managers and the board. I do not know whether you have any comments to make on how to improve the way that informal complaints are dealt with on ward, and dealt with very quickly, so that problems do not escalate.

[165] Mae'r ail gwestiwn yn ymwneud â newid y diwylliant hwn rydych chi a Keith Evans wedi sôn amdano, a'r diwylliant yn y bwrdd a chan y prif weithredwr o ymdrin â chwynion. Un peth roedd adolygiad Mid Staffordshire yn ei ddangos oedd bod tryloywder a gwybodaeth gyhoeddus yn bwysig iawn er mwyn newid diwylliant a gyrru gwella perfformiad. Ar hyn o bryd, mae rhywun ond yn cael gwybodaeth ar nifer y cwynion sydd wedi cael eu gwneud drwy *freedom of information*, er enghraifft. A ydych yn credu y dylai fod rhyw fath o log cyhoeddus o nifer y cwynion y mae unrhyw fwrdd iechyd yn delio â nhw? Rydym yn gwybod bod nifer y cwynion yn cynyddu, ac mae hynny'n gallu bod yn rhywbeth da yn ogystal ag yn rhywbeth drwg. Mae'n gallu bod yn adlewyrchiad bod gan bobl y grym i deimlo y gallant gwyno, yn ogystal â bod yn adlewyrchiad o'r ffaith bod mwy o broblemau yn y gwasanaeth iechyd. Felly, a ydych yn credu y dylai bod mwy o wybodaeth gyhoeddus ar gael yn rhwydd ynglŷn â nifer y cwynion mae byrddau iechyd yn delio â nhw, er mwyn gwella perfformiad?

The second question is to do with changing this culture that you and Keith Evans have talked about, and the culture within a board and from the chief executive for dealing with complaints. One thing that the Mid Staffordshire review showed us is that transparency and public information are extremely important in order to change a culture, and to drive improved performance. At present, one only gets information on the number of complaints made through freedom of information, for example. Do you think that there should be some sort of public log of the number of complaints that any health board is dealing with? We know that the number of complaints is increasing, and that can be good as well as bad. It can be a reflection of the fact that people have been empowered to feel that they can complain, as well as a reflection of the fact that there are more problems within the health service. So, do you think that there should be more readily available public information on the number of complaints being dealt with by health boards, in order to improve performance?

[166] **Ms Clwyd:** Ydw. Rwyf wedi gweld hynny yn Lloegr. Mae rhai ysbytai da iawn, lle mae eu harferion, rwy'n meddwl, yn symbol i ysbytai eraill hefyd, lle maent yn cyhoeddi nifer y cwynion, ac yn eu rhoi i fyny ar y ward, fel eich bod yn gallu gweld, 'Doedd dim cwynion yr wythnos hon, ond roedd hyn a hyn o gwynion yr wythnos wedyn'. Rwy'n meddwl ei bod yn bwysig bod pawb yn gwybod hynny. Os ydych yn gwybod bod pobl yn cwyno, a bod cwynion yn cynyddu, mae gennych broblem, onid oes?

Ms Clwyd: Yes. I have seen that in England. There are some very good hospitals, where their practices, I think, are a symbol for other hospitals too, where they do publish the number of complaints, and they put them up in the ward, so that you can see, 'There were no complaints that week, but there were so many complaints the following week'. I think that it is important that everybody knows that. If you know that people are complaining, and that complaints are increasing, you have a problem, do you not?

[167] Roeddem yn awgrymu rhywbeth syml iawn fel pensil a phapur wrth ymyl gwely rhywun—wrth gwrs, nid yw pawb yn gallu ysgrifennu os ydynt yn sâl iawn—fel bod pobl yn gallu nodi beth sy'n bod. Maent wedi dechrau gwneud hynny mewn rhai ysbytai yn Lloegr. Ond mae rhai ysbytai nad ydynt, hyd y gwn i, yn cadw cyfrifon cywir iawn o'r hyn sy'n digwydd, a'r math o gwynion sydd wedi bod.

We suggested something as simple as a pencil and paper next to someone's bed—of course, not everyone can write if they are very poorly—so that people can note down what is wrong. They have started doing that in some hospitals in England. However, there are some hospitals, as far as I am aware, that do not keep very accurate records of what is happening, and of the kinds of complaints that have been received.

[168] Felly, rwy'n meddwl bod eisiau edrych ar hyn yn fanwl ym mhob ysbyty i sicrhau system gyffredinol, yn lle bod system

So, I think that we need to look at this issue in detail in all hospitals to ensure a consistent system, rather than a system that is

sy'n cael ei gwireddu mewn un lle ac nid yn y llall.

implemented in one place and not another.

[169] **Elin Jones:** Felly, mae gwybodaeth hyd yn oed ar lefel ward yn gallu bod yn ddefnyddiol i wella perfformiad.

Elin Jones: So, information even on a ward level can be useful to improve performance.

[170] **Ms Clwyd:** Ydyw. Rwy'n meddwl bod yn rhaid ichi wybod pwy sy'n gyfrifol amdanoch chi—pwy yw'r arbenigwr sy'n gyfrifol amdanoch chi. Nid yw manylion felly ar gael yn aml iawn. Gofynnais i rywun sydd mewn ysbyty yn fy ardal i yn ddiweddar pwy oedd yn gyfrifol amdani ac nid oedd ganddi syniad. Mae'n rhaid ichi gael enwau pobl, yn enwedig pan mae patrwm sifftiau yn newid bob tri diwrnod ac mae wynebau yn newid. Rwy'n meddwl ei fod yn bwysig eich bod chi'n gwybod. Mae rhywun mewn gwely mewn sefyllfa anffodus iawn os nad ydynt yn gwybod â phwy i siarad neu i bwy y dylent gwyno. Felly, rwy'n meddwl bod yn rhaid edrych ar yr holl faterion hynny. A yw hynny'n ateb eich cwestiynau chi i gyd?

Ms Clwyd: Yes. I think that you have to know who is responsible for you—which specialist is responsible for you. Those kinds of details are very often not available. I asked someone in a hospital in my region recently who was responsible for her, and she had no idea. You have to have people's names, especially when shift patterns change every three days and faces change. It is important that you know. Somebody who is in a hospital bed is in a very unfortunate situation if they do not know to whom they can speak or to whom they can complain. So, I think that we need to look at all of those matters. Does that answer all your questions?

[171] **Elin Jones:** Ydyw.

Elin Jones: Yes.

[172] **Kirsty Williams:** Ann, it is clear from your report and from Mr Evans's report that neither the NHS in Wales nor the NHS in England deals with complaints well. Do you have any evidence to suggest that the way that Wales deals with complaints is any less robust or any less effective than what you been able to identify in England? You said earlier that some of these complaints should never get to the ombudsman stage. The kinds of issues that you have been talking about are fundamentals of care, and one would suggest that they should not ever arise. Have you been able to draw any conclusions as to what the barriers are on the front line that mean that those fundamentals of care are an issue that feature in complaints? Again, are you aware of any evidence that would suggest that we are doing any worse in Wales than England?

[173] **Ms Clwyd:** There are regulators now in England. There is the Care Quality Commission. To begin with, it was not fit for purpose, and they kicked out the whole of the Care Quality Commission and had a new Care Quality Commission. There is a very active health inspectorate—I know that you are aware of the difficulties that the inspectorate has had in Wales and that you are addressing some of those problems now. So, in that way, I am able to make a comparison.

[174] Things were not perfect in England by a long shot. There were good hospitals and there were bad hospitals and there were some in-between hospitals. However, one of the things that the Keogh review managed to do was to root out some of the bad practices and, in fact, put certain hospitals into special measures. Sir Mike Richards, the chief inspector, this morning said that half of the hospitals that were put into special measures have been taken out of special measures and they have their normal status back. When I last met Mike Richards, he was expanding his area of examination and was going into hospitals over which they had concerns with a team of about 45 people to turn them upside down to try to find out what was going wrong. That is why I have always felt that there should be something like a Keogh-style review or whatever you call it. It may already be under way; I do not know. However, you

need that kind of examination of hospitals that have problems, instead of waiting for something to happen that means that you have to have an outside group come to look at it like the Andrews review, for instance, did recently. I think that some of those things can be pre-empted, and that is why the Keogh-style look at things has been useful in England. However, you have to decide what is appropriate in Wales.

[175] **David Rees:** Clearly, it is the complaints process that we are focusing upon. Do you believe, therefore, that if we address the complaints process, and some of the points that Keith Evans is making, particularly—and you have mentioned chief executives very often today—the chief executive's role in the whole process and the board's responsibility for the whole process, that that will go a long way to addressing this because, as you start analysing the points, you can address the points that seem to be coming up as a consequence of that analysis?

[176] **Ms Clwyd:** I think that chairs of boards and chief executives have a huge responsibility. I will not say where they were from, but a set of board minutes that I looked at recently were, I would say, almost incomprehensible. I have, in the past, done something called 'a patient story', where you address a board and you say what went wrong—that was many years ago. I would like to suggest that lessons were learned from that. However, lessons very often are not learned and somebody has to ensure that they are learned and that recommendations are implemented. That is absolutely essential, and that is why I think that, in the absence of a beefed-up health inspectorate, you need a regulator, as Keith Evans suggested. I fully support that suggestion that he made.

[177] **David Rees:** Kirsty, you have a final question.

[178] **Kirsty Williams:** I want to go back to the question I asked earlier to try to get an answer. What analysis have you done, or why do you think that complaints about the fundamentals of care feature so largely in the complaints process? Why do you think that is?

[179] **Ms Clwyd:** I think that it is mainly because that is what the patient experience is and that is what the relatives of patients experience. They cannot believe that asking for something as simple as an extra blanket can get a reply like, 'There are no extra blankets', and, when pushed further, to be told, 'That is what the laundry has decided'. That is absolutely ridiculous, and relatives or patients should not have to push for something like that. It is so simple, it is unbelievable. Then, with things like water, everybody knows that hydration is absolutely essential, but too often, there are many examples where there is not a drink of water for somebody. There is one example in my report, which is not from Wales, of somebody whose two wrists were strapped up. Their food was plonked at the side of the bed, but that person could not possibly feed themselves; somebody had to help them to eat. You hear of many cases where relatives have helped out and have stayed and fed somebody. Obviously, people do not mind doing that on occasion, but then they worry about what happens when they are not there.

[180] **Kirsty Williams:** I appreciate that, and we have all had stories and examples like that, but what I am trying to get an understanding of is whether you have drawn any conclusions at all in your work as to why those issues arise in the first place. Are we saying that there is a deliberate attitude of non-caring, or are there other reasons around finance or staffing levels that make those issues such a common feature in the complaints process?

[181] **Ms Clwyd:** Really, I would say that that is down to management—either the management on the ward or management higher up. It is management, and it is their responsibility to make sure that these things do not happen.

[182] **Kirsty Williams:** That is clear; thank you.

[183] **David Rees:** Our time is up. Thank you very much for attending this morning. You will receive a copy of the transcript to correct any factual inaccuracies that you identify. Once again, thank you for your evidence and thank you for attending this morning.

[184] **Ms Clwyd:** Diolch yn fawr.

[185] **David Rees:** I now recommend that we have a 10-minute break and return at 11.10 a.m.

Gohiriwyd y cyfarfod rhwng 10:59 ac 11:10.
The meeting adjourned between 10:59 and 11:10.

Ymchwiliad i Broses Gwyno'r GIG: Sesiwn Dystiolaeth 3
Inquiry into the NHS Complaints Process: Evidence Session 3

[186] **David Rees:** Good morning. I welcome Members back to this morning's evidence session in which we are holding our short inquiry into the NHS complaints process in Wales. For our third session, we have representatives of the health boards in Wales. I am going to ask you to introduce yourselves, if that is okay. We will start from my left and go to my right.

[187] **Mr Farrelly:** I am Rory Farrelly, director of nursing and patient experience at Abertawe Bro Morgannwg University Local Health Board.

[188] **Ms Williams:** I am Nicola Williams, assistant director of nursing at Abertawe Bro Morgannwg University Local Health Board, and I have been leading on the transformation work that we have been doing in relation to concerns.

[189] **Ms Battle:** I am Maria Battle, chair of Cardiff and Vale University Local Health Board.

[190] **Dr Jones:** I am Chris Jones. I was a GP, but I am now chair of Cwm Taf Local Health Board.

[191] **Ms Shillabeer:** Good morning. I am Carol Shillabeer, deputy chief executive and the nurse director at Powys Teaching Local Health Board.

[192] **David Rees:** Thank you very much and thank you for your attendance this morning. We have also received a written response from the Welsh NHS Confederation, so I thank it for that. We will go straight into questions, if that is okay with you. I will start with Gwyn.

[193] **Gwyn R. Price:** Thank you, Chair. This question is to all of you, really. We have heard from Keith Evans and Ann Clwyd about complaints being a 'gift' to the national health service. Do you believe that national health service complaints should be taken as a gift and analysis of them taken on board to improve the national health service?

[194] **Dr Jones:** We will field the questions as best as we can, because—

[195] **Gwyn R. Price:** Yes, there are so many of you.

[196] **Dr Jones:** If I may, I will start. Yes, it is a gift but it is also a curse. We would love to have a service where there were no complaints, but, actually, if there were no complaints, we would probably be deaf. So, I think the sensitivity that we have is to use these as learning experiences, and to try to develop services that do not create repeat complaints.

[197] The other thing is that there is a great responsibility on us to make this service the best it can be. I think Keith's comment about how he has used complaints and issues as an engine to generate improvement is where we would all want to be.

[198] **Gwyn R. Price:** Do you all agree with that?

[199] **Ms Battle:** Yes, I agree with that. I would just like to add that Keith says something in his report about receiving complaints and concerns with heartfelt thanks. I think that that is totally true. He talks about receiving them with humility, compassion and care, and I think the same applies to staff concerns as well. The staff are also the eyes and ears, and what we hear from staff is also a gift. I think that one of the major things in his report is about trust, communication and enabling people to speak out and changing that culture. As chair of quite a big health board with fresh eyes and ears—because I am new into the health authority as of a couple of years ago—I think it is the responsibility of the chair to make that happen, to be seen and to put things in place. So, for example, after the Francis report, I wrote to every single member of staff saying, 'We all make mistakes, and we learn from them. Poor care is never acceptable, and we all have a personal responsibility to do something about it; if you find you cannot for whatever reason, my door is open'. From that, I have had quite a number of people come to me, thankfully, from walking the wards, listening to them, and enabling them to speak out—then they need to see the action, as well as being protected. I think that what we are not very good at is showing some of the examples of the action that has been taken.

[200] **Gwyn R. Price:** So, it is communication, communication and communication, as was famously said once. It applies there.

[201] **Ms Battle:** Absolutely, across the board with staff and patients.

[202] **Kirsty Williams:** One of the issues that comes out of Mr Evans's report is that often complaints teams are poorly resourced, poorly trained, poorly supported and perhaps isolated within an organisation. What steps are boards taking across Wales to address that?

[203] **David Rees:** We will ask the chairs to respond first.

11:15

[204] **Dr Jones:** Okay. My complaints team sits right next door to my medical director, sits right next door to my nurse director, and is in the same building as my chief executive. We walk through our open office, through the complaints department, three or four times a day. My chief executive sees all of the complaints and signs off all of the letters that go out to patients. We tend, actually, to have personal contact, when we can, before things become formal. We have a system in place—this is no different, I think, to other health boards—that, I think, is too defensive, or has been too defensive, and we are on a cultural journey. I think that the learning from the Francis review has been really important and I think that the way that my board members are out in the service, walking around, also gives you the smell and the taste of the service. I also receive thank you letters. There are occasions when I actually get involved first hand in resolving complaints. We meet the ombudsman regularly, once a year, and we meet Health Inspectorate Wales once a year. I have to say that putting the patient experience in the board papers is a piece of work that we are all working on and I think that is a fundamental thing. There is no one thing that tells you whether the system is okay. You cannot get assurance on one thing; you have to have quite a big picture. I heard Ann's comments about putting things into plain language, and I think that we need to be very plain about what is acceptable and what is not, and that needs to go right down the organisation. You can only do that by being visible and communicating it.

[205] **Ms Battle:** I agree. From Cardiff and the Vale, there are a number of things. Keith's report has reinforced both the experience that I have had through the office of the children's commissioner and elsewhere in reviewing complaints, but also what we are trying to do and the journey that we are on. So, just to briefly summarise, we held a complaints meeting and we randomly selected people who had made complaints, together with Velindre and the Welsh Ambulance Services NHS Trust, and it was an excellent evening. Some simple things were suggested, which we are implementing, such as badges showing who is in charge—'I am in charge'—a suggestion box next to the bed, having one thing on the internet, and mandating everyone, which we have already done, to make contact with the complainant. It is not a letter-writing exercise; it is about making human contact with people. I have invited this group of people back in six months' time, so that they can personally hold me to account for having implemented the things that they have suggested. I regularly meet complainants, and not just in Cardiff and the Vale, because we serve the rest of south Wales. I have met one person in your constituency, Lynne, a number of times, and I regularly meet the complaints lead, who is an incredibly caring individual, and, obviously, the director of nursing, I meet weekly. We meet weekly because of what I just described before about staff—we call it 'the safety valve'—so, we meet weekly to get an update on that and I feed back directly to staff and I feed back directly to complainants.

[206] I think he talks in his report about doing things differently. So, for example, with one complainant who talked about an awful ward, I took her back to the ward to meet the staff and to see the changes. It is a rich source of expertise. Some complainants are coming in as lay champions and we are setting up a citizen's panel, but there is a lot more that we need to do. So, for example, reading about the resources, I am really attracted by that central team with cross-professional expertise with a lawyer, and with clinical expertise, with more clout. I am also, personally—and we have not discussed it across the NHS in Wales—attracted, for those very serious complaints, by a national team, which really gives independence, expertise, et cetera. I think that a good example of that, Kirsty—it may be; we need to see how it has worked out—was one of the recommendations from the 'Clywch' report when we had the independent national investigation team for very serious cases of abuse in education. So, I would say that we have a lot in place that we are not communicating well enough, and I think that this has been a really good catalyst to look at strengthening it even more. Like Chris said, it is every board, et cetera.

[207] **David Rees:** Before Chris comes in, I will ask Carol to respond, obviously, but I am conscious that we have a panel of five and therefore time will be eaten up. We have quite a lot of questions, so I ask you to be as brief as possible. Carol.

[208] **Ms Shillabeer:** Thank you very much. I shall do my best. I think that there are a couple of points that I would make. One is the focus on prevention and working at the patient level to prevent complaints in order to ensure that the whole experience is improved and, where there are issues or concerns, that those are dealt with quickly. That is by far the best answer.

[209] Where things are perhaps more serious and cannot be resolved, we need to ensure that those who are on the front line have the support and access to the leadership to help them to do that. The NHS is a people business: it is run by people for people and it is complex. So the key, critical issue is about the personal touch. For example, at board level, we absolutely make it our business—in particular, the chief executive and the director of nursing and the other clinical executives—to lead on complex complaints. So, we are actually in support of the complaints department, because one thing that is clear is that, over the last few years, we have been expecting our complaints department to expand. So, we have implemented a patient experience framework across Wales. So, we no longer just wait for the complaints to drop on our mat or ping into our inbox; we actively seek feedback on issues and on our service. So, speaking from our own perspective in Powys, that has put pressure on our

complaints and our patient-experience department. So, there is an issue of resourcing that we need to look at, but there is also an issue of the support. This is an emotional business and I just wanted to make a point about those people who are bereaved. In my experience, it is those cases that require the most tender care in order to help people through that. Often they may well have just a question or a query or will need some information; they may not want to complain. That is why the recommendation in Keith Evans's report about finding alternatives to help people with their concerns other than just the complaints process is really welcome. We are attempting to do that more and more so that people do not feel that they have to write that letter of complaint, which often they really are very reluctant to do.

[210] **David Rees:** Nicola, do you wish to add anything to that?

[211] **Ms Williams:** Within Abertawe Bro Morgannwg, we have looked at resources in a wider context. Yes, you have the resources of the central complaints or concerns handling team and, within that, it is ensured that the resources include the correct skills and expertise. So, it is not just about people who have always worked in complaints or who have come up through an administrative function, but about adding clinical expertise within that team, because what we are dealing with are health issues and we need to ensure that staff understand what they see and what they talk to people over the phone about and can then interpret that in relation to having an appropriate response and an appropriate investigation.

[212] We have also looked at resources in relation to our information systems. Evidence has already been given this morning in relation to the themed analysis and the ability to really look at and drill down into it. However, we have to ensure that we have the best possible systems available for that to happen. So, certainly we have addressed that and we have a new system that we are putting in place. More importantly, picking up on what Carol said, we are really looking at our staff at service delivery level and ensuring that we have supported them with the correct skills, with the correct expertise, and with nipping issues in the bud and customer-care-type training, making sure that they feel empowered to deal with issues and to address issues as they arise. We are also putting information out there so that the patients and their relatives know that we want to hear their views and we want to know if things are not going the way that they should be going, as they arise, so that we can address them and stop them accumulating and stop that feeling of mistrust that may occur. So, that is quite multifactorial; it is not just about the central complaints team, but about the whole organisation.

[213] **Kirsty Williams:** Earlier, Mr Evans said that he felt that how complaints were being dealt with had not been high on the agenda of the Minister and the director of NHS Wales when holding boards and executives to account. So, the focus has been very much on finance, getting budgets in on time, waiting times and other initiatives and targets. That has been very much what the focus has been on in holding chief executives and chairs to account, rather than on this particular area of your work. Do you feel that that is the case in your experience and would you agree with Mr Evans that this area of your work should be regarded as being equally important in your discussions with the Minister, if you are a chair, or with the director of NHS Wales, if you are a chief executive?

[214] **Ms Battle:** I can say that, in my personal meetings with the Minister, he specifically raises that with me, particularly the fact that he knows from feedback that I am actually getting out there and meeting complainants directly. I think that it is worth considering. Again, we have not had the opportunity, collectively, to discuss the recommendations, but because of the way the system does work, I think that it is worth considering that becoming one of the tier 1 targets.

[215] **Dr Jones:** We have had complex conversations, as a group of chairs, with the Minister, and in our one-to-ones and appraisals, about culture and about being very specific in

responding to the Francis report. We have had a complex conversation about the risk-adjusted mortality index, mortality and the meaning of life. I think that, throughout the last three years, the discussion about the patient experience, and about us as chairs leading the boards to be visible and tangible, has been really involved, in that the Minister has been into the discussion, as was the previous Minister.

[216] **David Rees:** Do you have any more questions, Kirsty?

[217] **Kirsty Williams:** No, that is fine, thank you.

[218] **David Rees:** Okay. I have Lynne, then Darren, and then Andrew.

[219] **Lynne Neagle:** We heard from previous witnesses that, despite the best efforts, there is still a culture of fear among staff in terms of coming forward to flag up concerns. Maria has highlighted some of the things that she is doing in Cardiff and the Vale to tackle that. Can we hear from the rest of the panel in terms of what everybody is doing to actually create a culture where it is the norm for staff to flag up concerns about care?

[220] **Ms Williams:** If I can just expand further on what I was saying earlier, as part of the work that we have been doing within ABMU health board, from the very top of the organisation, the chairman and the chief executive have been driving this agenda forward. We are putting in-your-shoes events on for members of our staff, at all levels, to come to meet and discuss with members of the board their experiences of working within the health board, and to raise issues. However, on a more individual level, we are launching a 'see it, say it' campaign, which will be permanent, not just a campaign, where we are encouraging, not only members of staff, but relatives and patients, to make contact with named individuals through a dedicated e-mail address and telephone line, so that we can meet and encourage people to come forward with issues or concerns that they may have, and examples of good practice as well, because it is not only about the negative; it is also about celebrating the good practice. It is about starting to create that open, transparent culture. Also, managers are being trained and reminded of how they then must deal with issues that are raised with them, so that they are actually seeing those through, because if issues are raised, we have to follow that through, and, more importantly, feed back to staff members, and members of the public, regarding what action has been taken as a result of that.

[221] **Mr Farrelly:** From an openness and transparency point of view, this is actually quite a crucial thing. It is about some of the conversations that have gone already around culture and openness, and actually the time that it takes to change that. One thing that we have done as a board, since I have come into post, is that we had 20-odd patients come and talk to every board member—from the chair to all of the executives, to the non-officers—and actually share their experiences of using our services. That has been quite a powerful and unique event, and it has been quite a privilege to hear from patients and families in relation to how they use the services. So, there is something about the leadership of this, as Maria has already mentioned, and that is led through the organisation. Then, there is the leadership and visibility at all levels, throughout the organisation. So, for example, last week, I was at one of our sites and in clinical areas, talking to teams, and asking open questions about what one wants to happen. However, this is something that will take time, and I think that Keith Evans mentions that in the report, around culture. But, it is important that it stays as a key issue on all levels—at board level, and all the way down.

[222] **Ms Shillabeer:** I will just add a couple of points. I think that we have absolutely got to recognise that this is an issue. So, we have got to continue to work to do the things that we are doing, to support staff to come forward, to raise issues of concern, as a matter of routine. We will not solve this overnight—I feel really clear about that. The big issue for us will be the proof in the pudding. So, when a staff member does raise a concern, what happens? How are

they treated? Do we make it worth their while to raise that concern? Does it get fixed? Are we saying, 'Thanks very much for raising that and this is what has happened'?

11:30

[223] I was pleased to see, in Keith Evans's report, a note where he said that his sense of it is that staff are reporting and that they are feeling more comfortable in raising issues. That feels good. The critical issue is, when things go wrong—and inevitably, from time to time, although we wish they would not, things do go wrong—how we work with staff to support and sometimes challenge practice, to help to put things right and make a difference.

[224] I just wanted to make a note on the numbers issue—the numbers of complaints and the numbers of incidents. I think that we need to be very careful about making judgments that high numbers mean poor practice. If I am in an organisation where staff are reporting incidents, I am happier than being in an organisation where staff are not. It shows that people want to flag an issue. So, I would just put that note of caution about that. We want to see the reports coming through and we want staff to feel comfortable. But, for us, from an accountability perspective, it is how we lead that culture to making the improvement with staff and not getting to—I know you have discussed blame earlier—this issue of blame, because that is not going to get us anywhere.

[225] **Dr Jones:** I walk the wards, I visit GPs, I visit pharmacists, I sit in dining rooms, I go in on night shifts, I talk to my AMs on a regular basis and I have an open-door policy with my unions. My chief executive has an e-mail address and anybody can send anything in, whether they wish to put their e-mail address on it or not. We absolutely act. We demonstrate that we have considered and acted and we are particular about telling staff about the difference that they have made and what we plan to do. If necessary, we will support staff if they feel that they can no longer work in an area or a field. But I have to say it: we have some tremendous colleagues working on the front line—nurses, doctors and therapists. It is very stressful, because they see people in distress. The number of elderly people that were in our A&E departments two years ago was extremely distressing. The other thing that I think helps staff is when things feel controlled and organised. I have to say that the flow work that we have done in Cwm Taf has contributed to a stronger feeling of being in control. Our two matrons in our major hospitals have made a huge difference in terms of nipping in the bud issues that could get away. But, on this whistleblowing thing, I think that we are not having enough of it. We just have to keep working at it and pick up best practice. I am happy to say that our board will adopt whatever can be identified as good practice, because I think it is in the interest of the professions, the patients and us as a board to do this together.

[226] **David Rees:** I am conscious of the time, so I am going to stop you, Maria, because we have had a lot of questions and we had a lot of repetitious answers. We move to Lynne.

[227] **Lynne Neagle:** I wanted to ask about something else. We had some suggestions that an independent regulator would be good to improve the system. I would be interested in your comments on that. We also had a suggestion from Ann Clwyd that all health boards should publish details, obviously anonymised, of their complaints. I wondered if you would favour that, and also whether you have any comments on how we reconcile that kind of openness with the need to avoid demoralising staff in the system.

[228] **David Rees:** Maria, I stopped you last time, do you want to start off?

[229] **Ms Battle:** Chris, do you—

[230] **Dr Jones:** Openness, yes. In terms of a regulator, we are going to do a properly thought-out piece of work on Keith's report, but I think that a regulator could be very helpful.

I do not know how to construct it, but I think that all of us would feel that, if it makes it better and it gives assurance, then fine. I think the board papers need to be improved. We are attempting to include performance—I think that patient experience is intrinsic to performance—and we are looking at different models of doing that across the health boards. We just have to go with it a while to develop what people can understand and get value from. In terms of openness at the board, though, there are some cases that would be easily identifiable. I am very sensitive about that. Other than that, I think that with numbers and types, there is no issue at all. If you go to our website, there is some information already. If you delve through our board papers, there is a considerable amount of information there, but you have to really look for it.

[231] **Ms Battle:** I think that that is the issue. It is published, but is any human being going to be able to find it? It is not good enough for it to just be at boards. One of the things that I am trying to drive in Cardiff and the Vale is to have regular public meetings with our partners to share the information and the action—what we are doing about it. For example, in the appendix, with the ombudsman, I think, Ann, you raised questions about that. I recognise some of those, but I also know that there have been actions since then, but we are not communicating that enough in a way that is accessible. Vis-à-vis board reports, I have mandated two sides of A4 in plain English. We are talking about a lot of very clever scientific people. We are not there yet, but I want to get there, because, sometimes, I find them difficult to understand. We are on that journey.

[232] **David Rees:** Okay, Elin, do you just want to come in on this?

[233] **Elin Jones:** Specifically, on the availability of data on numbers of complaints, I certainly think that they should be in the public domain and more accessible. One way of doing that, of course, is to use the mylocalhealthservice.wales.gov.uk website that is hospital specific as well, so that that might allow transparency on the number of complaints per hospital, just as mortality data are highlighted, rather than going through board papers. So, you all look as if you are nodding and that that is a good idea—

[234] **Ms Battle:** Yes, it is a good idea.

[235] **Dr Jones:** I also think that we should include activity as well. I think that we should include activity and case mix information, because some hospitals are dealing with much more complex cases and some hospitals are dealing with really complex comorbidities. The devil in the detail behind the RAMI data will also go into complaints and incidents. So, it is something that we have to work through, I think.

[236] **Ms Battle:** Yes, and I think it has to be a range of things, because a lot of people, particularly older people, will not access the website, so it is about having different methods of communication.

[237] **David Rees:** Lynne, is that okay? I see that it is. Darren is next.

[238] **Darren Millar:** Thank you, Chair. You are telling us in your evidence that you take complaints seriously, that you try to deal with complaints and that you actively keep a listening ear out for them, if you like. However, Keith Evans's report, frankly, does not necessarily chime with what you are telling us this morning. For example, in Cwm Taf, Dr Jones—your health board—of the complaints that are made, only 30-odd per cent are actually responded to within 30 days. If that was my record, of concerns and complaints that might come into my office, I would be sacked; I would be out of a job. Who is holding you to account for this very poor performance? Your record, Maria Battle, in Cardiff and the Vale, is not much better—

[239] **David Rees:** One question. Be fair, Dr Jones will answer the question and then we will come back to you.

[240] **Darren Millar:** It is the same question. Your record in Cardiff and the Vale is not much better—it is just over 50%. In Powys Teaching Local Health Board, the figure is one of the higher ones at 70%, but you have fewer complaints per year—around 160—so you ought to be hitting 100%. What on earth is wrong with your systems if you cannot get an initial response out to somebody within the 30-day period? Who holds your feet to the fire if you fail to do that?

[241] **Dr Jones:** I hold my feet to the fire myself—

[242] **Darren Millar:** You are not doing a very good job of it.

[243] **Dr Jones:** Hang on—

[244] **David Rees:** Give him a chance to answer.

[245] **Dr Jones:** That—

[246] **Leighton Andrews:** That is not fair. [*Inaudible*.]

[247] **Dr Jones:** Let me put it this way: that 30% performance is not good enough and it is not acceptable. On the other hand, I think that what is important is that the responses are good and thorough responses, and also that not only does the patient feel that it has been thorough, but that the clinicians involved feel that it has been thorough, fair and open. I am afraid that some of that delay is down to the staff we have and the complexity of some of the things that we are dealing with. I would not underestimate the complexity. You will also note that some of the other figures go in the other direction. We do very well in some things. So, it is not all one thing, Darren, and that bit is not good enough. If it is a critical thing, then I see the Minister on a regular basis and the AMs that I have undoubtedly hold me to account.

[248] **Ms Shillabeer:** Thanks very much for the question. The response is in a couple of points. One is that, absolutely, timeliness is a key issue. I think that you can do the quickest response and still miss the point, so if you have not satisfied the complainant of the issues, but you have delivered a letter in five days, that is not a good outcome for us.

[249] So, I particularly want to speak to Powys because you have specifically asked a question about Powys. The approach that we take is to make contact with the complainant straight away, and tell them, 'We've recognised your issue. We are going to get onto it. We'll keep you informed'. So, the 30-day issue is about the final letter. Actually, we are corresponding and linking on a personal basis with complainants. There are a couple of types of complaints. There are those that are straightforward. There was an issue with a dirty toilet, which is the one that I always use. There was no argument; that was sorted. However, where there are very complex pathways—so, for example, for Powys, where we work into England, and we have multiple providers—our effort is to try to make it as simple as possible for that complainant to get one response. So, we will work with the local authority and we may work with trusts in England and health boards in Wales to deliver that. That will inevitably take a little longer.

[250] In terms of the answer that I gave earlier to Kirsty's question about resources, yes, there is an element of resourcing in there, but I would rather us get it right and that the complainant feels satisfied than to do it quickly. The outcome, therefore, is if you were to have a look at the ombudsman cases that go from Powys, you will find that we are really pleased that, actually, they are very low, and very unusual, because we are attempting to get

that complaint resolved. If that takes a little bit longer, we are working with the complainant to do that.

[251] **Ms Battle:** I would say that that is not good enough. It needs to improve. That is why we are asking clinical boards at the moment, on top of their day job, to be at accident and emergency departments at 3 a.m. and back at 11 a.m. to actually investigate complaints. That is why I am attracted to a centralised team of mixed professionals so that they can concentrate on their job. I like what Keith said about bringing people in, but this meeting with complainants, I believe, is the most important thing. When you meet with complainants, it goes from your head to your heart. Also, what they might put on a piece of paper is not actually what they are complaining about. The report also states that some complaints need to take a lot longer. Some are very complex. So, I think that we need to be simpler, but also have more common sense in this process.

[252] **David Rees:** Keith Evans actually identifies in his report that the 30 days is a generic point. There are some that would take less time, and some that would take longer. I think that he recommends that perhaps they should be categorised as a consequence. Do you agree with that?

[253] **Ms Battle:** Absolutely, yes. We grade them now, so perhaps that should equate to that particular level of gravity.

[254] **Darren Millar:** I appreciate that complexity might be an issue, but the complexity issues apply to most of the same health boards. Yours is slightly different, of course, in Powys, yet your rate is half that of others. The question that I asked, of course, was who holds you to account for this poor performance in terms of timeliness, accepting that sometimes you cannot get a response out in 30 days if there are particular issues that require further investigation? So, I was not looking for excuses; I was looking for a very clear answer as to who holds you to account for those particular issues. Secondly, in terms of patients' experience, I have noticed in the NHS Confederation paper a sense of satisfaction that 94% of patients have a positive patient experience in Welsh hospitals. That, of course, is to be welcomed and applauded, but we must not forget the 6% of patients—a higher rate than one in 20—who are not satisfied with their experience, and that only a very small proportion of those actually make a formal complaint or raise a formal concern. So, how are you capturing feedback, not necessarily complaints, in order to prevent a complaint necessarily having to be raised in the future?

[255] **Ms Battle:** May I pick up the accountability question? Excuse me for not answering directly.

[256] **Darren Millar:** That is all right.

[257] **Ms Battle:** I think that there are a number of ways that we are held accountable at the moment. One of the things that you, as a committee, and the Minister are going to be considering is this regulator and the recommendation of both Keith and Ms Clwyd. At the moment, we are held to account by the Minister directly as Chairs. We are appointed by the Minister. We are held to account by the ombudsman, who, in a way, partly plays the role of regulator. I think that the interrelationship with a new regulator should be taken into account. We are held to account by the media, which, in some ways, is a very good way to be held to account, although, in some ways, it is disproportionate. So, I think that that falls full square into your question about the role of this regulator.

[258] **Dr Jones:** The nub of the answer is simple—we need to be more sensitive than the formal complaints. To do that you have to understand what you are expecting the service to do, as well as the experience of the user when they receive that service.

11:45

[259] So, on one level, you could measure the risk adjusted mortality index, you could measure mortality rates, and you could measure outcomes—that is, whether they can walk after their hip operations, and whether people are more functional after some of the procedures and lengths of stay. However, there is always that one person who has had a bad experience, because someone has said something awful or they were demeaned. So, we spend a lot of time looking at dignity issues, and sometimes it is the dignity issue that really pushes the experience over the top. On our wards, you will see charts showing, 'When did we last have a complaint?', and, 'When did we last have an incident where someone fell?' What I am very keen on doing is actually listening to some of the relatives, and I think that some of the softer stuff that we hear builds up into a bigger picture. So, the consistency of some of those messages, particularly in the care of complex elderly people, is something that I think we have to learn to bring into the organisation and deal with.

[260] On the 6%, I think that that is an underestimate. I think that the thing is so biological—you know, people are people, and they are frightened. They are in a place where they have lost power, and they are often dependent on someone else to represent that power. We are seeing a change in the balance of the numbers in that category, and medicine is not as straightforward; the benefits of doing things are very difficult, and they are very personal. So, I think that a personalised health service, such as we are trying to do in the NHS, is becoming more and more stretched as the elderly become more and more complicated and greater in number. In a way, that is a sign of success. In another way, I think that it is the challenge for every health and social care system across the world, and it is coming at us at pace. The change has been dramatic in the past three years.

[261] **David Rees:** Thank you. I am conscious of the time, Darren, so I would like a very short question.

[262] **Darren Millar:** It is a very simple final question.

[263] **Ms Battle:** Did you want us to answer about how we measure patient experience?

[264] **Darren Miller:** Yes, on patient feedback.

[265] **Ms Battle:** Absolutely.

[266] **Ms Shillabeer:** If I may, Chair, I will keep it brief.

[267] **Darren Millar:** Very briefly, as I have a final question.

[268] **Ms Shillabeer:** There are just so many ways in which we do it. The first thing to say is that, increasingly, we are asking patients to enter into a partnership with us, to help us to design things. So, where a new service is being thought about, they are with us and they are saying, 'This will be good, or that would be good'. So, we are trying to design a service with people.

[269] The other key things are that you have your surveys, your focus groups, and your walking the wards and having a chat with people, but the other key issue that I wanted to pick up is to ensure that we are broadening our approach, not only with patients, but with carers, relatives and our staff. What we are trying to develop is an environment in which care can flourish and is broader than the sharp end of the complaint. So, increasingly, our focus has been on that sort of breadth of getting feedback in terms of how it feels to be a patient here, how it feels to visit, or how it feels to work here. We know that if you have staff who are

feeling supported and engaged, they will deliver engaged services with patients—not necessarily to patients, but with patients. I would be very happy to give you more information on this, because I know that, right across Wales, we are taking a very active approach on patient experience, and the complaints element is a part of it. I think that we recognise that that needs to be perhaps more prominent, and we certainly need to tell people where we have made a difference because of complaints that have been made or feedback received.

[270] **David Rees:** We would be happy to receive that in a written form, as we are behind time now. You have a very quick one, Darren.

[271] **Darren Millar:** This is my final question, and it is to ABMU in particular. I was very pleased to hear about the 'see it, say it' campaign. We have heard a lot about the culture of people not wanting to report problems and their staff members, and, like all Assembly Members at this table, I occasionally get approached anonymously to report matters that are taking place in our hospitals. Do you think that it is time that, in Wales, we had a similar duty of candour for staff in the NHS, as is now the case in England as the result of a law change there?

[272] **Ms Williams:** I absolutely agree that we must have a duty of candour. Certainly, we have had that approach, through being open for quite some time in Wales, and that is something that we are continually rehearsing with staff and revisiting. It is absolutely essential that we have that approach.

[273] **Darren Millar:** Thank you.

[274] **David Rees:** Andrew, do you have a quick question?

[275] **Andrew R.T. Davies:** Thank you, Chair. I appreciate that there is pressure on time. If I may just make a point, I think it would have been—certainly from my perspective and I appreciate that there is committee pressure—helpful to have the chairs in and then the executives in separately, on the basis that—

[276] **David Rees:** [*Inaudible*.]

[277] **Andrew R.T. Davies:** From the evidence we have had, there does seem to be a real problem at board level and at management level. I mean, this report that is before us today is dated 11 June 2014, so it is a very recent report and yet a lot of the talk today is of what the health boards are doing and how they are engaging. We have a detailed report here that says that it is just not happening. It is just not happening, and there are 100 recommendations here. The important thing from my perspective, as I have said to previous witnesses before us—

[278] **Leighton Andrews:** [*Inaudible*.]

[279] **Andrew R.T. Davies:** —before us—

[280] **Leighton Andrews:** [*Inaudible*.]

[281] **Andrew R.T. Davies:** I appreciate that the Member for the Rhondda might want to interact, but it is my session, with respect.

[282] **David Rees:** Let us focus on the question.

[283] **Andrew R.T. Davies:** With respect, the point I am trying to make to you is that, five years ago, the NHS Redress (Wales) Measure 2008 was going through the committees here in the Assembly. We were told that that was going to be a revolutionary piece of legislation that

would deal with the complaints process and actually get the health boards focused on the job of listening to people, whether they were employees or patients, so that we would not end up in this litigation culture we have at the moment. My point to you is this: do you generally believe that the criticism levelled at you as the boards is fair criticism, and that you have taken that on board and that you are fundamentally changing the nature of the way you run your health boards in order to address the problems that people have faced and that have led to these types of reports being commissioned?

[284] **David Rees:** Before you answer that, just for Members' purposes, the sessions were arranged and agreed within the committee, so there should be no criticism of that.

[285] **Andrew R.T. Davies:** It was an observation.

[286] **David Rees:** The Member was not part of the committee at that point. Chris, go ahead.

[287] **Dr Jones:** Go on, you go first, Maria.

[288] **Ms Battle:** Thanks. May I just very briefly say that legislation and policies, however well intentioned, do not change culture? The biggest issue in Keith's report is about culture, and I can honestly say, since I have come to my board, what he has identified as the culture was the culture that staff told me about when we undertook a massive listening exercise, and we are trying to change that culture, leading by example, and it will take time.

[289] **Dr Jones:** I listened to Keith's evidence and I had the pleasure of talking to him previously. When he was asked about how long this takes, his answer was that you work back from a 20-year trajectory. That is not good enough. What I am trying to communicate here is that we are on a journey, that we have not just waited for the report to come out, and that we are committed and focused on the most important thing in my professional life, which is the patient experience and the outcome for the patient. In that regard, there is no difference between being a GP and being the chair of the health board. I think that one of the things that he did pick up on was the variance in the different parts of the journey where we all are. I think that, as chairs, we have a huge responsibility to do some of the things that bring that learning together. I share your impatience with getting on with it, and I can honestly say that the culture bit and the candour bit are the keys to keeping this alive. I am not letting it drop.

[290] **Andrew R.T. Davies:** To the executives, if I may, the point I would like to raise is that the evidence we had several years ago was of incident forms not going above a certain level of management, especially staff incident forms. They ended up in the ward manager's desk or at some level above but did not actually arrive at board level. Can you confirm that that kind of culture change has occurred where, when instances are reported, they do flow up the chain of command to the board level and are dealt with with the seriousness they deserve?

[291] **Ms Shillabeer:** Absolutely—absolutely, categorically. In my organisation, instant reports, using a system called Datix, come up through the quality and safety unit and, as an executive director, I get copied into every single one of them, so I can see every single one. Where they reach the serious-incident threshold, we have a report on each one to our board's quality and safety committee, with the action that has been taken to put redress in place and to learn the lessons, which is something that we are still trying to improve—how we learn the lessons. This is a big issue right the way across the NHS, and we also have a specific focus on redress cases. Where there has been any sense of harm to a patient—be it a fall or a pressure ulcer—we will review those in detail. So, I can feel quite assured, from my own organisation, that staff are using that system. The number of incidents, which I referred to earlier, is being maintained, and that is positive. Do we need to do more? Absolutely we need to do more. We have a track record in NHS Wales of dealing with patient safety incidents under our 1000

Lives campaign. We have had a lot of success in relation to that. Our focus now has to be squarely on improving the patient experience. It is not just enough to mend somebody's hip; they have to have a really good experience as they are having their hospital or even community care. So, I can answer very categorically that, absolutely, at board level, we are seeing those serious incident reports.

[292] **David Rees:** Okay. I am going to stop at that point, because I have two people who want to ask questions and we have only a couple of minutes left. Leighton is first and then Elin.

[293] **Leighton Andrews:** I have a very short, simple question. Can you tell us the proportion of the complaints that are about GPs and the proportion that are about hospitals? Dr Jones knows why I am asking that.

[294] **Dr Jones:** Well, Leighton, you will know that I have gone out of my way to listen to communities that feel that, if they complain, they will lose their GPs and will have no service. You will know that it has been a mission over the last 10 years of conversations with communities. We do watch the number of complaints in general practice, we do get involved, and we have been very active as a health board in dealing with those issues that have been brought to our attention. However, it is probably understated, and I think that the complaints system needs to be looked at in primary care. That is as much for primary care's benefit as it is for the patients' benefit. It is, I think, one of the areas that health boards—. Given that we are integrated, the integrated system makes this a huge job, but there is a great benefit for the Welsh NHS because it is integrated. It is a journey and it is going to take time, but I think that we really do need to look into complaints in terms of dentistry, pharmacy and general practice.

[295] **David Rees:** Unless any other members of the panel have a different answer or specific figures, we will leave it at that.

[296] **Leighton Andrews:** Could we have a note from each of the health boards on the balance and the proportions—

[297] **David Rees:** Yes, but we will not just ask the members of the panel; we will ask all of the health boards.

[298] **Leighton Andrews:** Yes, all the health boards, Chair.

[299] **David Rees:** Okay. Elin is next.

[300] **Elin Jones:** You have all been very clear on your willingness to take these issues seriously and to see improvements in the way that complaints are dealt with at a very early stage and then how they are dealt with finally, if they become serious complaints. However, what I am not clear about is this: you are all, as individual health boards, going at this and improving at a local health board level, but is there any structure in place for you as health boards to peer review your work and progress, to share best practice, to share what is not working, to be clear to the Minister and the public more generally as to how progress can be seen to be being developed and ensure that there is consistency? Very often, when we get health boards to this committee, we tend to get those that are the best-performing on particular issues and then we tend to think that the others are being hidden from us because they are not here. So, you must be the best-performing, by that analysis. I am very keen to understand what the process is in order to ensure that there is a consistency that develops on this.

[301] **Ms Shillabeer:** I think it may be of interest to note that the NHS, right the way

across, has already established some peer-review mechanisms. Using the support of HIW to structure that in terms of specific areas, I see no reason why we cannot develop that system further to cover issues of complaints, concerns and the broader patient experience. We have a number of mechanisms already, so, if you like, within our management structure, we have patient-experience leads, who have formed a network so that they are sharing practice. Equally, we have networks that include nurse directors, chairs and chief executives, where potentially we can utilise that. The issue about being open and transparent will mean that we need to continue to open our doors to scrutiny from whatever means. So, I did not want to lose the input of patients, carers and the community health councils in relation to that.

12:00

[302] Finally, there is a point about how we work together as a team in Wales, the NHS team in Wales. We spend about two days per year, I think it is, focusing on the key critical issues that the NHS in Wales needs to take forward. The patient experience has absolutely focused our minds on this, and we can use that to move this forward, in collaboration, I think, with Welsh Government and the regulators.

[303] **David Rees:** We have come to the end of the time allocated—well, actually, we have exceeded it. Thank you very much for your evidence. You will receive a copy of the transcript to correct any factual inaccuracies that you might identify. If there are any items that you have indicated you want to send to us, can you do so as a matter of urgency, as, obviously, we have a very short timescale within which to respond to the Minister and inform his thinking when he reviews the report. Thank you very much again.

12:01

Ymchwiliad i Broses Gwyno'r GIG: Sesiwn Dystiolaeth 4
Inquiry into the NHS Complaints Process: Evidence Session 4

[304] **David Rees:** We will now move into the last session of our inquiry. We have with us representatives from some of the professions and of staff. Good morning—actually, it is afternoon now. I welcome Dr Phil Banfield from the British Medical Association, Tina Donnelly from the Royal College of Nursing, and Mike Jones, who is representing Unison and is a member of the Unison health committee. Thank you all for your written evidence, which we have received. I am sure that you have been listening to some of the evidence sessions this morning, so you will understand the direction in which we are going. We are tight on time, so, if it is okay with you, we will go straight into the questions. I will start off with Gwyn and then move on to Lindsay.

[305] **Gwyn R. Price:** Good afternoon. Do NHS staff treat complaints as a gift?

[306] **Ms Donnelly:** I know that that is the title of the report, but I think that, if the truth be known, quite a number of the NHS staff whom we would represent—that is, nursing staff and healthcare support workers—find it, in some instances, well, in quite a few instances, immensely difficult to have their voices heard. As a consequence of that, about three years ago, the royal college set up a confidential telephone line, and I receive quite a number of compliments and complaints when I meet staff on a regular basis, and they also raise them through our own representatives at work, because they absolutely care about the patients and want to provide the optimum standard of care. So, if there was a complaints system that was conducive to making things better and actions being taken on the complaints as they arise, I think that that is when they would view it as a gift.

[307] **Gwyn R. Price:** We have heard that it could also be a curse, and that it works both ways. However, I think the overall picture shows that, if we can learn from complaints,

especially when complaint after complaint comes in, then we should do that. Would you agree with that?

[308] **Ms Donnelly:** I have to say that there are some organisations that are in learning mode. I am quite outspoken and you would think that it would be very easy for people to raise concerns. Increasingly, I am seeing a mind-set change among chief executives and chairs: when you raise things with them, they are more conducive to listening to what you have to say. It will not come as a surprise to many Assembly Members here that I still practice clinically, so I would ask to go in and work in those particular areas. Then, I usually have a one-to-one conversation with the nurse director and the chief executive.

[309] On occasions, the chairs have been involved. There have been circumstances in the past where, when I have raised things with some, one or two chief executives have asked me to sign confidentiality clauses about what I might find or have wanted to know why I am going in to see them. When you actually share the complaint—. This happened last week; I had five e-mails in from nurses raising matters of concern, conscious about working on a telephone line. Those have all gone into the nurse director. I had a telephone conversation with the chief operating officer, and I also copied that to the Minister for health. So, in the past, I have raised things of concern, where the environment has not been conducive to me speaking out, with Healthcare Inspectorate Wales, and I know that it has gone in because it then contacts us and gives us the report about what it has found. I will say, however, that I have been in this job for 10 years and I can definitely see a sea change in the way in which the current healthcare communities are seemingly wanting to deal with complaints. I heard a couple of the other speakers say this morning that there needs to be a timeline to enable that process to happen. I think that there also needs to be the confidence within the staff, because staff do still feel that if they raise matters or concerns their job will be on the line, perhaps not immediately, but certainly in six months to a year further down the line.

[310] **David Rees:** I just wonder whether Phil Banfield or Mike Jones wish to add anything.

[311] **Mr Jones:** I think that Tina is right; things have improved. I am aware of a few health board chairs now who encourage staff to come to raise concerns. However, again, I agree with Tina that staff are still worried about raising concerns. They are, and some fear—dare I say it—some form of retribution as a result. However, the unions are helping staff with this and we are encouraging staff, particularly within Unison—all of our members—to fill out incident forms, to report things, and to share things with us if they do not feel that they have the confidence to report issues themselves. Things are improving, but, as Tina says, I think that we have a long way to go.

[312] **Dr Banfield:** They are a gift if you are armed with the tools to put things right. Sadly, we have it reported from our members that they are often not given the tools to put things right, so they become rather burdensome, because one gets repetitive over pointing out that the patients are sharing the same concerns as the staff and nothing is happening.

[313] **Gwyn R. Price:** I read in the Unison letter here, and, obviously, that is overwhelmingly coming across, that the fear is still there.

[314] **Mr Jones:** It is still there, yes.

[315] **Gwyn R. Price:** We really need to work together because the boards are saying that it is improving, you are saying that it is improving slightly, but it is not improving enough for them to come up front and say exactly what they think.

[316] **Mr Jones:** From my point of view, we have had many issues raised by the staff who actually deal with the complaints themselves—the complaint co-ordinators. That is,

obviously, across Wales. The view from that group of staff is that there are not enough of them. There are not enough of them, and they are under immense pressure. So, I think that we do really need to look at the staffing issues around the co-ordinators across Wales to help the situation.

[317] **David Rees:** I will allow a quick question on this, Andrew.

[318] **Andrew R.T. Davies:** May I just come in on that very specific point? On the co-ordinators of the complaints procedure and the departments—and, Mike, you touched on a very interesting point about the morale or the thinking of the individuals within those departments—is it just literally a resource issue or is there a bigger picture here of corporate denial going on, and that that is actually pushed down into those complaints departments, or do we just need to look at the resourcing of those departments?

[319] **Mr Jones:** The information that has been shared with me, as far as I am concerned, is that it amounts to a resources issue.

[320] **David Rees:** Lindsay is next.

[321] **Lindsay Whittle:** Thank you, Chair. I do believe that we should have had these witnesses in before the last lot of witnesses and then the questions might have been a bit tougher for the previous set of witnesses. Obviously, NHS staff are the greatest asset. You can build the best modern hospitals in the world, but, without the proper staff in them, they are no good.

[322] I am concerned about the effect of negative publicity on NHS staff and indeed, patients themselves. We have heard some quite outrageous statements here today. Earlier on, a witness said that people had complained that, when they were asking questions of nurses, they were too busy on eBay—I find that hard to believe—and that whistleblowers were ringing anonymously for fear of losing their job; I might believe that. I am very concerned because, as a member of this committee—I do not need to speak for other political parties—if I felt that a whistleblower was going to lose his or her job, then I would stand shoulder to shoulder with that whistleblower, and I am sure that you would as well, and send a clear message to managers, executives, board members and chairs of boards that we would hunt them down if that was their attitude to whistleblowers who had a genuine concern. I think that that message should go out loud and clear—

[323] **David Rees:** Can we get to the question please? We are short of time.

[324] **Lindsay Whittle:** I will. There is mention of patients who fear worse services from staff. What are you doing to help counteract the negativity of all of this publicity, and what can we do to help?

[325] **Ms Donnelly:** I think that right at the centre of any negative publicity is that there is a patient or prospective patient waiting to go into that health care environment. It will increase their anxiety if they are constantly reading or hearing negative press about the way in which their services are supposedly delivered across the board. From our perspective, we do quite a lot of that activity, to try to get some transparency in systems and processes where issues have been raised. You asked a question with regard to counteracting that negative publicity. If you work as a nurse anywhere in the NHS these days, quite a high proportion of the activity, because nurses are there 24/7, is geared around nursing. However, if we started to do root-cause analysis of why those nurses are performing in that way, the element of learned helplessness because it has been prolonged activity for so long, with regard to the ever-decreasing resources across the NHS—. I am not just waving a banner saying ‘We need more staff; we need more resources’. We have to do the root-cause analysis of each of those

complaints. It is not sufficient to say that somebody has not had fluids or a drink or that they are dehydrated. You have to look at why that is the case. If you happen to be on a ward with 36 elderly patients, quite a high proportion of whom have comorbidity, and a high proportion of whom have dementia, it is a really demanding special skill area to be able to deal with those people with compassion and passion, and you have to have the time.

[326] Many of you will know what it is like to go into a restaurant and, if you have a waitress telling you about the menu and talking to you about the meal that you are going to have, tipping the waitress when you walk out, because you thought that they were very caring. Let us give nurses the time to do that. What you currently find is that you have a resource-heavy burden on a particular environment, with comorbidity and quite demanding patients; I do not mean psychologically demanding, but physically demanding because of the comorbidity that they have. Yet, we have constantly talked in Wales, and across the UK, because we are a UK organisation, about matching the resource to the demand. I would like to see a complaints process. We have talked about an ombudsman or maybe an independent body looking at that. I would like to see some of the answers of the root-cause analysis when a complaint has been answered in relation to a patient. It is one thing to say to somebody, 'We apologise for the care; we acknowledge it and part of your complaint is upheld.' However, what we do not do, or what we cannot get access to, is the root-cause analysis as to what caused that complaint in the first place. If we did, it might be a completely different story if we started to resource some of that. I am not just talking about more money; I am talking about doing things differently. I think that I will stop there; I am passionate about this.

[327] **Dr Banfield:** If you do not have enough staff, at whatever level, to do the task that you are asking of them, mistakes happen. We know that from other industries. At the point at which the patient is making a complaint on an individual basis, individual staff members would like to be able to put it right straight away. What they get frustrated about is when the system above them either loses the complaint, or seems to ignore the complexity that puts them in that position in the first place.

[328] **Lindsay Whittle:** What about the whistleblowing issue? I cannot understand—

12:15

[329] **Dr Banfield:** Is it not a shame that we have to have whistleblowing—that our NHS does not welcome wanting to know what is wrong with it?

[330] **David Rees:** May I ask a question on this point? We have talked about root-cause analysis, and one of the highlights in the Keith Evans report was learning from the issues. Do you believe that there is not enough root-cause analysis going on at the moment to identify how we can learn?

[331] **Ms Donnelly:** All too often, I go into an area and talk to nurses who will say, 'I have raised this; I have put in incident forms and am being asked not to put in any more incident forms because people know about the problem'. They say, 'I have put in three or four incident forms on this particular issue'. They do not get the answers. When you look at the system, it is because incidents are numbered—they go into an electronic database and you then have to identify the number in order to find out what went wrong. It is not just about looking at getting a satisfactory answer to deal with a complaint and to appease somebody that part of their complaint was upheld. It would be more of a full system approach, to say, 'What is the root cause as to why that complaint occurred in the first place?'

[332] If you have complaints about people not getting adequate amounts of fluid or, indeed, not being fed appropriately, you have to look at why that was the case on that particular day. I have done that. I have gone into a health board where I was told that nursing staff did not

have sufficient staff to look after a patient or patients. That came from nurses. I went into a particular hospital and I asked which ward I should go to; I was given quite a few wards. I asked to focus on that. I went into that hospital and when I started to look at the root cause of complaints, on that electronic database, I found that 50% of the staff had been off sick over a period of time of six months, and two of them were off on permanent sick leave. Yet they were still being rostered. That is a root-cause analysis. Nurses were saying, for example, 'When I go to work tomorrow, those two are rostered'—66% of the qualified nursing staff on that ward were not present on duty. I knew about it because it was on an electronic roster. When I asked why they were still being rostered, I was told that it was because of the NHS pay system. If you go to another health board, you find that that information can be taken off the system, because you can put in parameters to take that information out of the computer database, so that they will not be rostered. The root-cause analysis of that is determining why the staffing levels are short, why the skills mix is not right and how you can start to put that right. That does require front-line staff and leadership.

[333] The report that I am talking about is 'Free to lead, free to care', which was about empowering sisters to manage that activity. However, there is disconnect between the front-line staff and the board in terms of the sticky middle. That is not to detract from the immense work that has to go on; it actually is the involvement of what goes on in terms of seeking to address those root-cause analysis issues, let us say.

[334] **David Rees:** Lynne is next and then Elin.

[335] **Lynne Neagle:** Staying on the subject of whistleblowing, may I ask you, as trade union bodies as well, whether you have had cases where people have been victimised because they raised concerns?

[336] **Mr Jones:** I am aware of someone being victimised for making a whistleblowing complaint. A few months later, that individual was taken through a disciplinary process for an alleged malpractice within the workplace.

[337] **Ms Donnelly:** We are the same. We would represent members where their initial complaint was about activity or care and, maybe four or five months down the line, it is a performance issue. Usually a compromise agreement in those instances is made, because there is a difficulty with regards to that and then we would come back to it. If there is a real issue, you have to represent those members and that is why we devised our raising matters and concerns guidance and provided telephone lines so that people could do that anonymously—not to us anonymously—and we raised it with the health boards. That is not unique to Wales; that is across the NHS.

[338] **Dr Banfield:** The short answer is that it is difficult to give details because of the culture of fear that still prevails, unfortunately.

[339] **Lynne Neagle:** On the staffing issues, the RCN survey said that 65% of nurses had had to raise concerns about patient safety, and of those more than half—54%—were about staffing levels. What, in your experience, is the response from the health board when it is told by front-line staff that they are concerned that the ward is not safe because of unsafe staffing levels?

[340] **Ms Donnelly:** This is a really big issue. Again, it is not unique to Wales. That is why we are doing quite a bit of work on safe staffing levels, because we know, from our root-cause analysis, that that is why some of the care delivery is not where you would expect it to be. From what we have done, and looking at the annual process that the NHS in Wales uses to commission student places, it does that on the basis of projected need. You are working on an annual budget, as opposed to maybe a three to five-year plan; yet, you are training many

people, whether they are allied health professionals or nurses—medicine is quite a bit longer—for about three years. So, you are trying to project forward what your service development needs are going to deliver and the staff to deliver on that agenda. We have done that repeatedly, year on year, as the college. We know what the triangulation of expenditure for agency and bank nurses are. We know that there is a disproportionate—. There is a correlation, we would say, but there is a disproportionate way in which the commissions are presented.

[341] From our perspective, it should also look at the number of complaints and the number of positive outputs. When I talk about root-cause analysis, if you have areas that you are concerned about, the light should be shone on those areas to look at the problems associated with an increase in complaints or the areas whereby you have really good work. There was some work done in Aneurin Bevan last year and the year before looking at the perfect ward, whereby staffing was raised to what was considered the appropriate level. Complaints went down—patients with high levels of dementia and acute orthopaedic trauma went through that—and sickness levels went down to less than 1%. There are models whereby you can look at the evidence and say 'This is exactly what is right'. There was ownership of the leadership within that environment.

[342] That is what I mean about root-cause analysis. So, there will be complaints that are not down to staffing levels. There will be complaints whereby you have to look, as Keith said in his report, at the customer service agenda. Actually, that is treating people with dignity and respect whenever you meet them. From that perspective, there will be those issues that potentially need to be looked at. If they are things where there are training needs, I would also go back to say, from an NHS environment perspective, that those things should be picked up in the annual person development plans of those staff with their line managers. If there are customer service issues, there should be sufficient staff to do those staff appraisals so you know exactly how your performance is being monitored at a ward level and you are encouraged to get patient feedback in relation to the care that you are giving. It would be a lot easier for staff if they knew that there are areas they need to improve and they have been made aware of that.

[343] **Elin Jones:** I wanted to ask about informal complaints on a ward level before anything becomes a formal complaint. It could be around a relative complaining about no water being available for a patient, nurses on eBay or issues like that. What do you think is reasonable to expect in terms of trying to log or capture the data on informal complaints? Keith Evans told us earlier that there should be a kind of incident log of informal complaints such as those. We heard Ann Clwyd say that, in some hospital wards in England, they have a big white board where they note down falls or any kind of complaints they had received—anonymised, of course. Of course, nothing of this nature should become too onerous on the people who are undertaking this work so that it becomes an additional burden that serves no purpose. What do you think is reasonable in trying to understand and collate the information, and whether there are patterns on informal complaints on a ward basis?

[344] **Dr Banfield:** I am not sure, if the complaint is dealt with there and then, that we need to spend a great deal of process collecting that information. It took me nearly 12 or 13 minutes to fill out a Datix form the other day for a very simple complaint. We would like to see that kind of receptiveness of dealing with a complaint there and then. I think that one thing that has come out is that, where it is systematic and repetitive, there needs to be an identification of that and an ability to escalate up. I think that that is where there needs to be joint ownership of what is going on on wards between patients, nurses, medical staff and everyone else, such as the cleaner and the person who makes the tea—their ability to be able to say, 'This doesn't seem right to us otherwise'.

[345] **Elin Jones:** How do you know whether it is systematic and repetitive unless it is

collated? It could be about—

[346] **Dr Banfield:** I think that Tina hit the nail on the head about putting the ward sisters back in charge of what is going on on their patch, because they build a pride and a receptiveness to want to know what is going on. That can then be escalated. They would pick up patterns very quickly.

[347] **David Rees:** Is it that we need to look at more empowerment for different individuals or ward sisters? Is the issue the empowerment of staff to actually take on these issues?

[348] **Ms Donnelly:** Yes, there is a 'Free to Lead, Free to Care' report, which was actually commissioned by Edwina Hart when she was Minister for health, and it was put into place. It was accepted. There were 35 or 38 recommendations in that. There was a group that looked at that. Within that, it identified that the ward sister should be empowered to take control of her environment, that she should be enabled to select her own staff, and that she should also be responsible for the whole system and process of staff management. That has not been completely put into place in all areas. However, there are already some systems and processes. There is the fundamentals of care audit, which exists throughout Wales, which came out of that process, whereby there is a 10% audit done whether the fundamentals are being delivered. That is one issue.

[349] However, Elin, in relation to where we were a few years back, where there was a complaints procedure at local level, you could have a complaints book or a comments book where staff and/or patients and/or visitors could comment on that, and it should be made available at each visiting time. However, if you are really in tune with your ward and your staff, you will know exactly when patients are dissatisfied. You will know exactly what relatives are saying to you, and there should be sessions made available during visiting time whereby the ward sister is freed up to talk to patients' relatives to actually assess their care. Those are the systems and processes that worked historically. We have gone out of that way of working, mainly because of the staffing levels. For a ward sister to be supernumerary to be able to conduct that very important front-end customer relationship type of environment, you will hear exactly what it is like from your patients and your visitors when you are actually—. It is almost like a quality control mechanism that you are looking, together, to get from your clinical leaders at ward level. As a ward sister, you should be conducting that, and then you will pick up the trends.

[350] **Elin Jones:** I completely agree, but when the ward sister does not do that, or is not able to do that—. You spoke about the logbook that patients, relatives and staff could all comment on. Are those books no longer in place? It strikes me that that kind of book provides some of the qualitative issues that a board member or a chief executive walking the wards one day would benefit from seeing, really. It is done in a book form, which is informal and more straightforward for people to feel that they can comment.

[351] **Ms Donnelly:** Some independent care homes will have those in the environment, and you will see them. The inspectorate will look at those and ask for your comments book. We will be saying that it is a process whereby you can put in place. It does not take away from the ability of the ward sister to actually make sure that they are communicating with the relatives and their staff to get a feel for that. I think that that is vitally important from the perspective that it will also pick out the comments that are positive.

12:30

[352] I think that Lindsay made a comment earlier today—or it might have been Leighton—about the cards that exist on the ward. There are huge numbers of 'thank you' cards that staff and patients see. That goes a long way to instilling confidence in the patient

too. When you are going into an environment and you see those comments of thank you, it instils an element of positivity that you will be cared for, and that, psychologically, is a huge uplift to patients when they are at their most vulnerable, coming into hospital. So, I think that we need to start looking at some of the simple measures to de-escalate some of those problems. Perhaps there should be a comments book and maybe we should also be looking at ward sisters being available to talk to relatives, so that relatives get reassurance about their concerns because they are part of the whole patient.

[353] **Dr Banfield:** This is the problem with the organisation not taking ownership of things before they become a complaint, because a lot of patients are just sitting there thinking, 'I don't know whether I should be complaining or not complaining' or a very junior member of staff may be finding it very threatening and saying, 'I'm not quite sure whether this is right or not'. Someone relatively senior in the organisation should be saying, 'Actually, we don't think this is right. We will take ownership of that. We will investigate it and put things right'.

[354] **Mr Jones:** We should allow the sister to run the ward, and I would agree strongly that the sister should be supernumerary. If I may, I will come back to the question on staffing levels. We do tend to focus on staffing levels with regard to nurses, and that is right, but what we are missing is focusing on staffing levels for cleaners and porters. Often, when those numbers are short, those nurses are fulfilling portering duties. They are escorting people to x-rays and other departments; they are emptying bins. The point I am making is that the sister should be there to run the ward and be supernumerary. The nurses should be there and they should be allowed to nurse on that ward, rather than carry out other duties. That is a common problem, I am afraid, across Wales. There are shortages in staffing levels in other areas, which takes nurses out of their main nursing role.

[355] **David Rees:** Darren is next.

[356] **Darren Millar:** Thank you, Chair. It seems to me that what you are telling us is that there is a fear sometimes of repercussions if a member of staff reports a problem or concern to a senior manager and that there is a lack of confidence in the ability of the managers to address the problem they might raise as well. So, there are two hurdles in the way of anybody bringing forward a complaint. Assuming that we get those right, perhaps by the introduction of a duty of candour in the Welsh NHS, how then can the Welsh NHS ensure that it is learning from complaints? What are your members' experiences of a complaint going through the process and there being something to be learnt from it and a change in practice that needs to be implemented? What sort of feedback do your members get on the ground in terms of a change in practice that is required as a result of a complaint that has been made and has gone through the process? Is there any feedback?

[357] **Mr Jones:** Unfortunately, in many areas, members do not get feedback. Members often do not get feedback when they fill out formal incident reports. They are not told what has happened, and often—and I am sure that Tina would agree with this—there is very, very little feedback, which will then make staff feel, 'What's the point in reporting things in the first place?'

[358] **Darren Millar:** So, there is little feedback to your members. Is that consistent in the BMA's and the RCN's experience as well?

[359] **Ms Donnelly:** From our point of view, unless it is raised formally with the college, which is why members do that—and that is when we go and are usually engaged for a prolonged period of time, and I am talking about a period of three months, where some of us will go in and work in that environment—. We have to validate the complaint. We have to validate what has been said. You prove that. I have had very open dialogue with the executive team and also middle managers who want to make a difference, and you can see the change in

that department when that is the case.

[360] **Darren Millar:** But it is only through your involvement, generally.

[361] **Ms Donnelly:** I would not want to claim to be omnipotent and say that it is just that. I am saying that the ones who bring it to us are doing that usually out of exasperation because they have filled in endless incident forms, things are not improving, they cannot cope with it any more and they are either going to go off sick or they are going to leave nursing, and that is the full spectrum. So, you can have a one-to-one with your ward sister, and if it is within her gift to be able to make improvements, then it will happen, although, invariably, there are some exceptions. Once it gets to be a resource issue, it has to be escalated, and that is when you do not tend—and I am generalising now, and I recognise that—to get the feedback.

[362] **Darren Millar:** Okay. So, that is in terms of concerns raised by members of staff. When a complaint is raised by a patient—obviously, we have many of those raised, usually post someone's experience in a hospital, or post someone's experience in GP care, or wherever it might be—what is the learning experience like for the NHS in those circumstances? If, for example, a consultant has a complaint made about them—it could concern a practice that is widespread within a clinical division—how is that reported back so that everybody can learn from it, Dr Banfield?

[363] **Dr Banfield:** I think that the NHS is trying to learn, and consultants are certainly much more involved in both local and more senior level incident reviews now. In fact, you are probably more likely to get a change in practice if it has come from a patient complaint or something that has happened to a patient than you are from a member of staff raising a concern.

[364] **Darren Millar:** Okay.

[365] **Ms Donnelly:** There is a system in place under healthcare governance procedures, whereby healthcare governance and clinical governance is the healthcare governance board, with ultimate accountability lying solely with the chief executive. Usually, it is the two individuals, just very slightly in health boards, that deal with healthcare governance and patients to make sure that those lessons are learned, because they are required to do so. It is similar to the CQC in England. They are required to be that mechanism, and that is the director of nursing and the medical director at clinical level. Again, however, that type of process has to come to the board. So, for the healthcare governance outcomes, where patients have raised complaints, and the actions on them, whether it is the seven domains of healthcare governance or a variety of different ways that each health board might interpret those results, they are required to have them delivered at board level.

[366] **Darren Millar:** I have a very brief question to Dr Banfield. One of the reasons that my health board suggests is sometimes a barrier to resolving complaints in a timely fashion is the lack of engagement, sometimes, from clinical staff. Do you recognise that as a problem, and how can clinicians actively help to support the complaints process, so that resolution can be made more swiftly for the patient? Is the time pressure on consultants a factor in their lack of engagement, because they are firefighting against waiting time lists et cetera?

[367] **Dr Banfield:** There are time constraints. Part of the difficulty in dealing with quite complex complaints is that the staff who are involved may be off on shifts or on annual leave or may not even be part of your health board anymore. Now, that should not actually hold the complaint up. It is unbelievably complex, and instead of me having a set of notes that I can read through and say, 'Do you want me to write the letter to the patient to explain it?', I have to give a response to the health board, it disappears off, and it then gets sent back to me as a draft, when I have to translate it again into words that the patient wanted, because I have been

asked for a technical report. So, it is unbelievably cumbersome, and I think that that holds it up, and I think that people are really trying to put a lot of effort into simplifying that.

[368] **Kirsty Williams:** Tina, you said that we need to ask the question as to why a situation has arisen that leads to a complaint. I am interested in your analysis of why management and boards do not seem to be able to create a system that allows any of your members to speak up, because the consistent thread through all the evidence is that people do not feel able to speak out, and that, if they do, nothing happens. So, just like we asked the question, 'What is the root cause of the practice that led to the complaint in the first place?', what is your analysis of what prevents boards and managers from acting effectively when your members raise concerns? They must be doing it for a reason. There must be a reason for that; what is it?

[369] **Ms Donnelly:** There are a variety of circumstances in which I would ask that question. One is that if you bring something to a board and you know that it is a significant risk to patients, and you are quite clear on that, and you bring it to the professional clinical people at board level—a medical director, a therapies director or a nurse director—they are duty bound to make sure that something happens with that. Invariably, there will be pressure put on the board by the professional organisations to make sure that they are not put at risk, and that is when we have been made aware of those issues. I am not saying it would just be us—it would also be the Royal College of Midwives and Unison and people like that.

[370] The other issue is that there are resource issues. If you ask the question and you get the answer, you have to deal with that process. That process is very difficult if you are in a situation where you have a spotlight on parts of the NHS that have to deliver, such as the 15-minute handover in an emergency department, the four-hour target, the eight-hour breaches and the 12-hour breaches—that is where your focus is. That is where our clinical staff will be saying, 'I don't think it's safe to move a patient who may be fitting or not breathing', and the answer may be, 'You will move that patient because you are in 10 minutes of breach', or 'That patient has breached now, you're into the eight hours, so you have four hours of a window of opportunity'. That detracts from the prioritisation of patients based on clinical need, and that is where there are real complex issues.

[371] So, in many ways, targets are there for a reason, because of a system that was seen to be failing, but there does not seem to be the scrutiny or review of those targets once that has been achieved or not achieved, and to see whether or not there are other avenues that we need to look at the full systems approach with that. What I am saying is that I still go back to the root-cause analysis; if you have a series of complaints in a department, and there are some real indicators and levellers that you can pick out, you owe it to your patients to make sure that that happens. When a clinician tries to raise those issues, which I have heard so many times before, the response is, 'I don't have the resource to deliver; please stop telling me about it', because middle management are just as frustrated about getting any action on that. There are resourcing issues.

[372] **Kirsty Williams:** Mr Evans said this morning that he felt that boards were much more worried about reaching their financial targets and reaching those clinical targets than concentrating on these areas, because that is what they were held to the fire over by the Minister or the director of NHS Wales. Would you share his analysis?

[373] **Ms Donnelly:** I would say that there is a duty on all politicians, because the Minister will have to answer to the opposition with regard to why the NHS is not delivering. It is about time that we all put the patient at the centre, and look at what those patients need and cost it out. That is a really difficult question for the resources and requirements of the NHS. We have to recognise that people are getting older, frailer and that there is a lot more wrong with them. The demands on the NHS—. I know it has been said here, but realistically, those

complaints are not going to go away if we continue to try to deliver an NHS based on everybody's passion about what they expect when they are sick, unless it is resourced appropriately, and resourcing is a huge issue, whether it is staffing, equipment or accessing appropriate care at the right level. I guess that there is an element on our behalf, as responsible people, to know when we are seeking to use the acute care service that we actually use it for acute care. I will stop there.

[374] **Dr Banfield:** I think that Mr Evans made the point about how complex the systems, processes and management in the NHS are. It is much easier to kick the person on the shop floor that is on the end of the mistake; it is much tougher to ask, 'How did we manage to put them in a position where that mistake happened?'

[375] **David Rees:** There are no other questions from Members, therefore, thank you very much for your evidence and your time. You will receive a copy of the transcript to check for any factual inaccuracies you may identify. Once again, thank you very much.

12:44

Papurau i'w Nodi
Papers to Note

[376] **David Rees:** The papers to note are the minutes of the meetings on 2 July and 26 June 2014. There is also the committee's forward work programme from September to December 2014. Are you happy to note those? I see that you are. Thank you very much.

12:45

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod ac o Eitem 1 y Cyfarfod ar 18 Medi 2014
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Remainder of the Meeting and for Item 1 of the Meeting on 18 September 2014

[377] **David Rees:** I move that

the committee resolves to exclude the public from the remainder of the meeting and for item 1 of the meeting on 18 September 2014 in accordance with Standing Order 17.42(vi).

[378] Are all Members content? I see that you are. Thank you very much. We will therefore go into private session.

Derbyniwyd y cynnig.
Motion agreed.

Daeth y cyfarfod i ben am 12:45.
The meeting ended at 12:45.