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Response of the Public Services Ombudsman for Wales to the Welsh Government's Consultation on the Review of Concerns (Complaints) Handling within NHS Wales – "Using the Gift of Complaints"

1. Introduction

1.1 I welcome the opportunity to respond to the consultation on Keith Evans's 'Review of Concerns (Complaints) Handling within NHS Wales – "Using the Gift of Complaints"'. As Public Services Ombudsman for Wales (PSOW), I investigate complaints made by members of the public that they have suffered hardship or injustice through maladministration or service failure on the part of a body in my jurisdiction. As such, I have a unique perspective on the provision of public services in Wales, driven from the views of members of the public who have been dissatisfied with the service they have received. In particular, grievances about healthcare account for a significant number (36%) of the complaints that my office receives. It is in this context, therefore, that I am responding to the consultation.

1.2 There are a number of aspects identified, and recommendations made, in 'Using the Gifts of Complaints' which I welcome. Indeed, a number of these reinforce concerns previously expressed by the PSOW in recent years about failings in the way complaints are being treated and dealt with by health boards and trusts. Nevertheless, there are aspects in relation to some of the conclusions and recommendations in 'Using the Gifts of Complaints' which cause me concern. Before I go into further detail, however, I will first of all turn to an inaccuracy in the document referencing the Ombudsman, as it fundamentally misrepresents the role and powers of the Public Services Ombudsman for Wales.

2. The Role of the Public Services Ombudsman for Wales

2.1 In the document 'Using the Gift of Complaints' it 'states:

> "The Ombudsman at present does not normally consider redress he usually only identifies breaches of duty. This means that the complainant has to work through a very protracted and unsatisfactory process. Even engaging the Ombudsman's complaints process can be quite lengthy before finally having to seek legal representation on the basis of the failings identified by the Ombudsman." (p.38)

This statement is incorrect. The role of the Public Services Ombudsman for Wales is summarised at paragraph 1.1 above. When considering complaints about public service providers in Wales, as Ombudsman, I look to see whether people have been treated unfairly or inconsiderately, or have received a bad service through some fault on the part of the public body. I will also give attention as to whether the public body has acted in accordance with the law and its own policies.

2.2 If I uphold a complaint I will recommend appropriate redress. The main approach taken when recommending redress is, where possible, to put the complainant (or the person who has suffered the injustice) back to the position they would have been in if the maladministration had not occurred. Whilst the Ombudsman is not a 'compensatory body' as such, it has long been accepted by the courts that an Ombudsman's report may include financial recommendations, if appropriate in the circumstances. Beyond this, if from the investigation I see evidence of a systemic weakness, I will make recommendations with the aim of reducing the likelihood of others being similarly affected in future.

2.3 Furthermore, the Law Commission recognises that "public sector ombudsmen are an important pillar of administrative justice in their own right". Increasingly, the Ombudsman is seen as an integral part of the justice system and is not merely an alternative to the courts.

2.4 I would also draw attention to the statement:

> "The Ombudsman acts as an external office to receive referrals for the most significant concerns although will often choose to refer a referral back for local resolution, before it selects complaints that warrant further formal investigation." (p.22)

This is misleading. Any person unhappy about the public service received (significant or not), or indeed lack of a service to which they are entitled, can complain directly to the Ombudsman. There is no 'referral' process and neither do they need to be represented (for example, by a solicitor) – although, of course, some service users may wish the support of a family member/advocate to help them to make their complaint. Further, the only complaints that I refer back are those where the health bodies concerned have not first been given the opportunity to address them via the 'Putting Things Right' (PTR) process. That does not then prevent the complainant from complaining to me if they remain dissatisfied after having given the health board/trust the chance to 'put things right'.

3. Putting Things Right (PTR)

3.1 The PSOW has been a supporter of the streamlined approach of PTR and I am of the view that this remains the right approach for a complaints process for the NHS in Wales. The problems with PTR lie not in the process itself but rather failings in its implementation. The PSOW has previously pointed to:

- inadequate resources within the health boards to deal with the complaints being made to them;
- a regrettably defensive culture within the NHS in Wales in relation to responding to complaints;
- the need for those charged with handling complaints within health boards/trusts to have the active backing of senior managers and boards to enable them to, for example, obtain prompt responses from clinicians;
- the need for health boards to provide challenge to the Executive and to ensure that learning from complaints is disseminated throughout its own organisation, but also shared with other health boards and trusts.

3.2 Issues such as these have also clearly been identified by the review undertaken by Mr Keith Evans.

4. Recommendations

4.1 I will now turn to the specific recommendations in the document. The PSOW has actively promoted the concept that there should be a common and streamline complaints system applied throughout the public service provider sector in Wales. Together, the Model Concerns and Complaints Policy, the Putting Things Right process and the recently introduced revised Social Services complaints process now provide that common approach, which consists of an informal resolution stage by frontline staff and one formal investigation by the public service providers themselves. Then, if people remain dissatisfied with the outcome of the investigation by the public services provider, they can then put their complaint to the Ombudsman for independent consideration. The comments that follow on the specific recommendations in 'Using the Gifts of Complaints' are made against this background.

4.2 **Making the System fair and independent for complainants** (**Proposal for creating of an Independent Complaints Regulator (R71 to R77)**

4.2.1 Whilst, as will be seen, I support the majority of the recommendations made, I will first all address a key area with which I disagree. This relates to the proposal for a separate Complaints Regulator.

4.2.2 I have serious reservations that, during a period of public sector austerity and the strides made for simplifying complaints procedures, establishing a new and separate Complaints Regulator would create unnecessary expense and add confusion. Indeed, in my view, creation of another body within the complaints landscape would be a retrograde step.

4.2.3 It is recognised amongst the ombudsman community that complainants are often suspicious of the objectivity of public bodies in addressing their concerns. They think that the individual making the original decision is likely to have an undue influence when reconsidering it, and also that internal complaint mechanisms are more likely to favour the original decision maker than the complainant. Nevertheless, it is accepted to be good practice within the other devolved nations, at UK level (both public and private sector), at European level and internationally that those organisations providing the service should have a complaints procedure in place and be given the opportunity to put matters right for the individual before the matter is taken to an independent body (i.e. an Ombudsman/independent complaint handler).

4.2.4 As mentioned a key objective in Wales over recent years has been to develop a streamline complaints process. A proliferation of complaint handling and regulatory bodies will, in my view, not make things clearer but merely add confusion to the complaints landscape. The Ombudsman is clearly the body in the PTR procedure to whom people can obtain independent consideration of their complaint, if they remain dissatisfied after it has been investigated by the health board/trust. It is difficult to see how a complaints regulator as described could act in a way which would be complementary to the role of the Ombudsman; it seems to me to be fraught with difficulties and would add even greater confusion in the minds of the public. It is unclear where the regulator would fit in to the landscape and on the face of it seems to be another stage in what was intended to be kept a lean process.

4.2.5 There is a framework already in place to deal with all those aspects of the role and duties proposed for the new Regulator and I find it particularly curious that the existing inspectorate and regulator, Health Inspectorate Wales, has been disregarded in this context. I have addressed each of the proposed duties contained at Appendix 1 in 'Using the Gift of Complaints' in detail in an Appendix to this response. Nevertheless, I will also make a number of key comments in terms of the existing infrastructure here:

- **Community Health Councils -** The advocacy role of the CHCs is a valuable one and the experience of this office is that this element of the service that they provide, on the whole, works very well. CHC advocates can play an important part in helping complainants put their complaint to health boards/trusts and also, if the complainant remains dissatisfied, to this office and support them through the complaints process. In fact, I agree with the conclusions of the Williams Commission, that rather than duplicate some of the activities of other inspection and scrutiny bodies, CHCs should focus on the advocacy services and 'patient voice' aspect of their role.

- **Healthcare Inspectorate Wales** – Whilst, the 'arms length' and independent status of HIW needs to be strengthened, HIW's remit already covers the areas of governance and 'concerns/complaints'. However, the Welsh Government needs to ensure that HIW is appropriately resourced to enable it to undertake this role effectively so that it can give the appropriate amount of attention to this aspect of its activities. Indeed, the current review of HIW, being undertaken by Ruth Marks, seems to be an ideal opportunity to address this issue.

- **The Welsh Government's Healthcare Quality Division –** It seems to me that the 'helicopter' view of what is happening in respect of complaints across the NHS in Wales would be something that the Healthcare Quality Division within the Welsh Government would wish to have (retain) ownership of. It was responsible for the development of PTR and it seems logical that it should monitor and analyse what is happening in terms of complaints in each of the health boards, benchmarking and identifying any indicators of 'problem areas', lessons and themes, etc. However, this could of course equally sit within the remit of HIW.

4.3 **Other Recommendations**

4.3.1 **Easy to access and use** - **R1 to R5 –** – I would endorse the proposals in these recommendations; they reinforce the principles and guidance contained within the Model Concerns and Complaints Policy and Social Services procedures.

4.3.2 **Getting Help to Access** - **R6** – I support the principle of this recommendation. However, it has to be recognised that different patients will have different support requirements. My office, particularly through the Complaints Wales service, holds a wealth of information on the various advocacy organisations in Wales who can help people make their complaint to either public services organisations or to my office itself. Whilst, clearly the Community Health Councils (CHCs) would be the most obvious organisations to have a presence within health boards and trusts, they may not always be the most appropriate advocates to support patients.

4.3.3 **Improvements to Complaints Process** – **R7 to 11 –**

- R 7 - I endorse this approach in relation to personal contact upon a formal complaint being made; it is again consistent with the guidance within the Model Concerns and Complaints Policy.
- R8 - I also support the call for attention to be given as to how complaint handlers can be given the support they require to enable them to meet the 30 day target for responding to complaints.
- R9 and R11 – These proposals are also consistent with guidance for the Model Concerns and Complaints Policy and I support them.
- R.11 – I again support the proposals in relation to escalation of complaints and consider this to be good administrative practice.

4.3.4 **Categorising complaints R12 to R14 –** Once more, I support these recommendations; the need for a consistency in categorisation is something which the PSOW has commented on in the past.

4.3.5 **Infrastructure and ICT Infrastructure – R15 to R24** – The PSOW has previously commented upon lack of appropriate resource provided by health boards/trusts to enable them to deal efficiently with the complaints they receive and indeed to effectively implement the PTR system. The proposals here seem to me to be eminently sensible and I support them. In particular, the PSOW has criticised the fact that there is a lack of comparable data and information held at an all-Wales level and I also welcome the proposals in this regard.

4.3.6 **Courteous correspondence – R25 to R27 –** I again concur with the recommendations made here. In particular, I would draw attention to an e-learning training package issued by the Welsh Government in June 2014. This is based on the key principles for effective complaints handling set out in the Model Policy and includes guidance on making a meaningful apology, which I encourage everyone responsible for the delivery of public services to take on board.

4.3.7 **Regulation – R28 and R29** – I have already commented on this issue above (at paragraph 4.2)

4.3.8 **Addressing Primary Care – R34 -** I concur that there is a need to reinforce PTR in the primary care area. It is clear from the complaints received by this office, that there is a widespread lack of appropriate training being provided for those responsible for complaint handling within GP practices.

4.3.9 **Investigation Expertise** – **R35 and R36** – I endorse these comments. In addition, the PSOW has previously stated that health boards should engage independent clinical advice during the consideration of complaint when the nature of the complaint warrants it.

4.3.10 **Increased visibility and awareness at all levels of patient contact – R42 to R46** – I welcome the proposals here which appear to me to be sensible in making a contribution to raising awareness of the PTR system.

4.3.11 **Commissioning responsibilities – R54** - I concur with the comments concerning the responsibilities of health boards/trusts in requiring appropriate complaints handling arrangements to be in place by those contracted. Again, the PSOW has commented on this in the past and, also, would mirror the section 'Complaints concerning services that have been contracted out' contained in the Model Concerns and Complaints Policy.

4.3.12 **Board Duties and profile – R55 to R58 –** I again support these proposals. These chime with the PSOW's previous comments about the need for Boards to hold the executive to account and to receive regular reports on the number and type of complaints received, their outcomes and any remedial action taken (or progress on their implementation) as a consequence. It also reinforces the PSOW's call for the need to consistent reporting, collated at an all Wales level, on complaint numbers, themes, etc.

4.3.13 **Patient Journey** – **R81** – the guidance at the Model Concerns and Complaints Procedure makes clear what the Welsh Government would expect to see in relation to complaints involving more than one public service provider. There are also provisions in the regulatory health (PTR) and social services complaints procedures to enable this to happen. In essence the model policy tells the complainant that if their complaint covers more than one body the organisation they complain to will usually work with them to decide who should take a lead in dealing with the complaint and that they will then be given the name of the person responsible for communicating with the complaint during the course of the complaint. Therefore, this again is a matter of complaints handlers in various organisations working to achieve this.

Public Services Ombudsman for Wales
August 2014

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Appendix - Response in relation to the proposed duties of a complaints regulator

Appendix

Response in relation to the proposed duties of a complaints regulator

As expressed in the main document, I do not agree that the functions identified during the review constitute the need for yet another public body to be created (which presumably would come within the jurisdiction of the PSOW in the same was as HIW and CSSIW). I address each of the duties in turn below.

Duty identified in Review document	**PSOW comment**
• The regulation of the PTR system for NHS Wales.	• I agree that the PTR system should be regulated but would argue that this would fall within the HIW's role to 'inspect NHS and independent healthcare organisations in Wales against a range of standards, policies, guidance and regulations'
• The investigation of complaint and incident data. /• Analysing trends from complaint and incident investigation.	• I also agree that this is a function that needs to occur. The PSOW has already commented publicly to this effect. I would have imagined that this is something that the Chief Executive of the NHS in Wales/the Welsh Govt's Healthcare Quality Division would wish to gather and analyse.
• Order higher and better quality investigation quickly.	• This suggests merely a referral of a case back to the Health Board to carry out a better investigation. Such an arrangement was unsatisfactory in the past; in particular, the further delay in complaints eventually reaching the PSOW's office meant that cases were so historic it was difficult to gather necessary evidence, including tracking down clinical staff who had invariably moved on from their posts.
• Question Boards over incident, concerns and complaints.	• This is a matter that could again sit well within the regulatory role of the HIW. However, I would also suggest that the National Assembly's Health and Social Services Committee would be interested in this field from the perspective of its scrutiny role.

Duty identified in Review document	PSOW comment
• Monitor change that should take place by action plan following complaint investigation by setting implementation deadlines with follow-through.	• This is a role that should properly sit with the Health Board itself as regards its role of providing challenge to the Executive and holding it to account.
• Ensure PTR accessibility is in full view and easy to access.	• Again, something that the HIW could give attention to as part of its regulatory role described above.
• Spread innovation from the analysis of complaints and incidents throughout Wales as a learning from complaints.	• This could be done as readily by Healthcare Quality Division of the Welsh Government as by the HIW.
• Be empowered to order best practice into other Health Boards and Trusts.	• The HIW is already well placed to do this (Note: the PSOW is currently only able to consider individual complaints.)
• Report and refer issues directly to the National Ombudsman, NHS DG and the Health Minister. / • Work closely with other bodies such as CHCs, AvMA, existing Commissioners and others for the betterment of patient experience.	• There are already networks and mechanisms in place to these ends (including HIW's summits).
• Regulate local patient advocacy schemes to help patients settle concerns and complaints at source or when necessary navigate the PTR scheme.	• Is this specifically referring to CHCs? If so, the Board of Community Health Councils in Wales is responsible for monitoring the performance of the Community Health Councils (CHCs), and performance of officers. It seems to me that this area would sit within the scope of the Board.
• To ensure the correct management of personal data and correspondence is upheld throughout processes.	• I would imagine that this could easily be programmed into internal audit and risk plans (and could be followed up by external audit by the Wales Audit Office)
• Ensure that the decision is accepted and the closure is final.	• This almost seems to close down the patient's right to take their complaint to the Ombudsman.
• Manage national public, safety and quality forum for open debate on user experiences within the NHS.	• Would this not be something that the Chief Executive of the NHS in Wales would want to have ownership of?

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