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Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Nick Ramsay, AM
Chair
Public Accounts Committee

Our Ref:AG/JM/TB
29 November 2016

Dear Mr Ramsay AM

Putting Things Right progress report

In response to recommendation 4 of the governance review of Betsi Cadwaladr University Health Board Public Accounts Committee report, the Committee requested regular (six monthly) progress reports on the review of Putting Things Right guidance and how it is being received and implemented by health boards.

Please find enclosed the first update for the Committee.

Yours sincerely

Dr Andrew Goodall

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Public Accounts Committee – Putting Things Right Progress Report – November 2016

1. This document provides an update to the Public Accounts Committee on progress around the review of the Putting Things Right system and the handling of concerns and complaints by NHS organisations in Wales. The report will be refreshed and presented to the PAC on a six monthly basis.

Background

2. Putting Things Right, a revised process for concerns, complaints and redress in the NHS in Wales, was introduced in 2011. It established a single consistent and proportionate method for grading concerns, an integrated process for their investigation, as well as more openness and involvement of the person raising the concern. It also introduced a new way of dealing with low level claims where the NHS organisation was found to be at fault and to have caused harm.

3. The overriding aim of Putting Things Right is for concerns to be investigated once and resolved to the satisfaction of all parties in an open and constructive way which facilitates learning - a philosophy of 'do it once, do it well'.

4. In 2014, an independent review into the Putting Things Right arrangements was undertaken by Keith Evans, the former Managing Director of Panasonic UK and Ireland. Mr Evans's report, *"Using the gift of complaints",* concluded that Putting Things Right was a good overall approach to managing complaints and concerns; however the report made over 100 recommendations where further improvements could be made.

5. The recommendations cut across a number of themes, including **culture and leadership**, **infrastructure, responsiveness** and **learning.**

Culture and leadership

6. The Evans review indicated that in order to achieve the maximum benefit and learning, organisations should draw on information from a number of sources, including patient and staff feedback, complaints, concerns, patient safety incidents, Ombudsman's reports and other intelligence. The whole organisation should share the aim of learning from feedback in all its forms - from boards to the front line. A number of high level strategies and expectations have therefore been put in place to support this way of working and we are seeing progress in a number of areas, as outlined below:

Health and Care Standards

7. In April 2015 new health and care standards were developed to include a specific standard around listening and learning from feedback.

   Standard 6.3 Listening and Learning from Feedback

   "People who receive care, and their families, must be empowered to describe their experiences to those who provided their care so there is a clear understanding of what is working well and what is not, and they must receive an open and honest response. Health services should be shaped by and meet the needs of the people served and demonstrate that they act on and learn from feedback".

8. Achieving this standard requires a robust, integrated approach by NHS organisations to dealing with patient experience feedback, including concerns. This will be monitored as part of the NHS Outcome Framework 2016-17 through the 'My voice is heard and listened to' in the Dignified Care indicator.

9. **Abertawe Bro Morgannwg University Health Board,** for example, encourages staff to discuss with family, friends and caregivers the role they would like to play in helping to provide care to their relative while in hospital.

Framework for Assuring Service User Experience

10. The Framework for Assuring Service User Experience sets out the range of methods and sources that we expect to be used to give a balanced view of experience. It was updated in 2015, following the Evans review, to link with the Listening and Learning from Feedback standard described above and includes the need to gain feedback from concerns, complaints, compliments and clinical incidents. This integrated approach to patient feedback aims to ensure that listening to patients and responding to concerns in a timely and effective manner avoids some concerns progressing to a more serious level. The Framework brings together feedback in four quadrants – **real time** (i.e. when patients are in NHS care); **retrospective** (i.e. following NHS care); **proactive/reactive** (i.e. follow up in-depth surveys) and **balancing** (i.e. concerns, complaints, patient stories)

Core questions for service users

11. A set of core questions for service users were developed to assist NHS organisations with the 'real time' quadrant of the Framework. All organisations are expected to use the core questions as part of their patient feedback methods. The core questions were developed to be used across all care settings, to ensure a consistent approach to determining service user experience across Wales. Information gained

from the questions and resulting service improvements are included in patient experience reports to NHS Boards and their Annual Quality Statements.

12. Organisations have also developed a range of different feedback mechanisms consistent with the Framework's four quadrant approach, for example **Betsi Cadwaladr University Health Board** is using *iwantgreatcare*, an online patient experience feedback system.

Betsi Cadwaladr UHB – iwantgreatcare

Results October 2016

Reviews this period	572
Average score for all questions this period	4.72 out of 5
Likely to recommend	93.9%
Unlikely to recommend	2.1%

Involving patients in the design of feedback systems

13. Involving patients from the outset in the way patient feedback is captured ensures it is relevant and appropriate, and that organisations understand what matters to their local populations. For example, **Powys Teaching Health Board** held a consultation workshop with staff and stakeholders to aid the development of their patient experience strategy. Their Board approved the Patient Experience Strategy in February 2016. An implementation plan is now being developed in partnership with staff and stakeholders.

Infrastructure

14. The Evans review found that different structures were in place for the handling of concerns, with variable resources and leadership arrangements. It also noted that the Putting Things Right arrangements did not seem to extend to primary care in the same way as secondary care. The aim of recent work has therefore been to place more consistency around the structures which support the handling of concerns both nationally and at NHS organisational/primary care levels.

National support

15. On a national level, a Listening and Learning from Feedback Group has been set up with representatives from all health boards and trusts as well as a range of key stakeholders. The group sets the strategic direction for the implementation of the recommendations from the Evans review and a series of work streams have been set up to take

forward the work. These include a group looking at the structures necessary to deliver this integrated approach.

Local structures

16. One way of achieving this is to bring patient experience and concerns management teams together to share information/patient feedback in a proactive way which makes organisations more responsive to patient needs.

17. Guidance has been developed by the Listening and Learning from Feedback Group which sets out the functions and leadership required to provide an integrated approach to the management of patient experience and concerns. This involved bringing the separate teams together under one executive lead and each organisation having a dedicated board level champion to challenge on these issues. This approach has now been adopted across Wales. It means that information can now be triangulated and shared across the team to help identify where potential service issues may arise.

18. An example can be seen in the **Welsh Ambulance Services NHS Trust** which has brought together concerns, patient safety and partners in health team under the Executive Director of Quality, Safety and Patient Experience. The aim of this change will be to provide a more joined up response for patients and clearer assurance that learning and improvement has taken place.

Primary care

19. The Evans review highlighted that the Putting Things Right did not appear to be as well embedded within primary care as it was in hospital services. There appeared to be confusion about where the responsibility lies for investigation of the complaint. A work group has been formed to look at the way health boards handled complaints that related to primary care. The group recommended changes to the Putting Things Right guidance for NHS staff so a process is in place for health boards to manage primary care concerns when a complainant wishes the health board to undertake the investigation. The work group also looked at a range of materials to help the individual primary care professions deal with concerns under Putting Things Right.
20. As an example, the Welsh Risk Pool assessment for 2015-16 noted that **Betsi Cadwaladr University Health Board** has a good process for handling primary care complaints under the Putting Things Right process.

Bereavement Services

21. The Evans review felt there should be greater support for patients and families in particular for those who have suffered bereavement. A working group has looked at the current bereavement support arrangements across Wales and has found that there is variability in the service provided. The group is developing standards and information to support bereaved families to reduce the variability in the system. It is also linking the work of bereavement services with the proposed new medical examiner system.

Responsiveness

22. The Evans review found in many respects the process of handling complaints to be impersonal and lacking in responsiveness. Recent work has therefore focussed on improving the communication around concerns, and on identifying which issues might be therefore handled informally, which many patients and families prefer.

Dealing with concerns informally

23. The Keith Evans review felt that the NHS should support and empower staff to deal with concerns quickly and at source by **"nipping them in the bud"** before they escalated into formal complaints. This will make it easier to encourage people to raise any issues about their care and treatment during their care, so giving staff the opportunity to put it right. The review also found that many complaints could be avoided by some prompt contact and communication at the outset.

24. One of main changes has been around dealing with concerns quickly and at source to enable early resolution and prevent them from becoming formal concerns to be investigated via the Putting Things Right process. Progress has been made in this area and a number of organisations now deal with as many concerns informally as they do formal concerns, as shown below:

	Informal Concerns 2015-16	**Formal Concerns 2015-16**
Abertawe Bro Morgannwg	1,099	1,291
Aneurin Bevan	939	1,008
Betsi Cadwaladr	2,313	1,905
Cwm Taf	125	446
Cardiff and Vale	1,217	1,083
Hywel Dda	1,710	774
Powys	67	154
Wales	7,470	6,661

25. One example of being responsive is where teams have developed a triage system of grading the concerns when they come in. This means that some of the lower graded concerns are dealt with immediately if the complainant is happy for this to happen. Another way this is being dealt with is via a Patient Advice and Liaison Service (PALS). PALS provide a central point of contact for patients and their families who need advice and support with a wide variety of issues that affect their overall care. They can address the "on the spot" concerns that may otherwise escalate into formal complaints.

26. Some organisations are reporting a reduction in formal concerns as a result. For example, in **Cardiff and Vale University Health Board**, 60 per cent of the health board's concerns are currently resolved informally. The conversion of informal to formal complaints in the health board is less than 0.5 per cent and is measured monthly as a Key Performance Indicator.

27. **Cwm Taf University Health Board** has a triage system for filtering and dealing with informal complaints which has helped reduced formal concerns by 200 in one financial year. It has also introduced Care to Share clinics which provide patients and relatives with an opportunity to raise any concerns they have with a view to 'nipping them in the bud'.

Communication

28. The Evans review identified that NHS organisations are generally more reactive than proactive in the way they communicate with complainants during the complaints process.

29. One of the national work streams looked at how concerns teams interacted with complainants. A key change was to encourage teams to contact the complainant on receipt of the complaint. This introduces a named person to deal with their concern and scopes out the nature of the complaint prior to investigation. This approach has, in many cases, led to complaints being managed on the spot. Complainants are often happy for their complaint to be resolved at the time, following discussion. Many organisations now offer meetings at the outset so that all parties are clear about the issues. This has proved popular with complainants.

30. **Hywel Dda University Health Board** has been cited by Welsh Risk Pool as an area of good practice for their work in meeting complainants to scope out their concerns

31. In addition, concerns teams are encouraged to keep in regular contact with the complainant. However, they are discouraged from issuing standard letters where no new information is provided. Concerns

teams are encouraged to ring complainants with realistic timelines for when they could expect a final response.

32. To improve communication with the public, a new Putting Things Right leaflet has been developed. A public engagement exercise was undertaken with the Board of Community Health Councils in Wales to gain feedback on what information the public would wish to see in the leaflet. The leaflet will be supported by a range of factsheets which aim to explain to complainants some of the legal terminology around Qualifying Liability and breach of duty.

33. NHS organisations have also redeveloped their websites to ensure that information about how to make a complaint is easily accessible from the front page. They have also developed a range of posters for display within the care setting to ensure that patients and their families understand how they can make raise a concern before they leave the setting. These also indicate where patients and their families can obtain support with their concern via the advocacy service of the Community Health Council.

34. Following the revision of Putting Things Right posters, **Cardiff and Vale University Health Board** had a 40 per cent increase in phone calls and e mails to the department rather than letters.

Dealing with formal concerns

35. Once complaints have been graded, some concerns will need to be investigated under the Putting Things Right arrangements. The concern is still scoped out and contact made with the complainant immediately. A named person is identified who will manage the concern.

Templates

36. One of the Evans recommendations was around the use of templates and some work has taken place on how template letters can strike the right balance between providing consistent standard information and lacking the personal touch. A number of standard paragraphs have been piloted across NHS organisations and are being refined accordingly. They have also been shared with the Public Services Ombudsman for Wales in order that they can feed in any comments/suggestions as part of their review work. These will be kept under regular review.

Learning

37. The Evans review concluded that formal learning mechanisms must be in place at all levels from Board to individual services to ensure that

learning from complaints and incidents is reviewed regularly and seriously, but more importantly that change and actions are taking place and being shared.

National learning

38. On a national level, the Listening and Learning from Feedback group is sharing lessons and good practice from all NHS organisations and key stakeholders. Additionally, there is a concerns network led by the Welsh Risk Pool that learn and share lessons around concerns and claims. **NHS Legal & Risk Services** have also recently appointed to a post specifically to assist with learning lessons around concerns and claims nationally.

39. All NHS Wales organisations are required to report patient safety incidents and near misses to the National Reporting and Learning System (NRLS). Data reported to the system from England and Wales is analysed to identify hazards, risks and opportunities to improve the safety of patient care. The data enables themes to be identified and the Welsh Government issues advice to NHS Wales in the form of Patient Safety Alerts and Patient Safety Notices. This advice is based on advice issued by NHS England but tailored to NHS Wales.

40. In addition, all NHS Wales organisations are required to report serious patient safety incidents to Welsh Government. These are also analysed to identify risks and opportunities to improve the safety of patients and can lead to the development of Patient Safety Alerts or Notices specific to NHS Wales.

41. A good example of a Patient Safety Notice which arose through specific incidents is that on Positive Patient Identification which was issued in April 2106. This came about through two mechanisms:

- inspection reports by Healthcare Inspectorate Wales which raised concerns about positive patient identification.
- serious patient safety incidents reported to Welsh Government around the safe administration of medicine, radiology and blood transfusions.

Local learning

42. Evidence from the Welsh Risk Pool assessments for 2015-16 showed organisations are better at learning from higher graded incidents than they are from lower level routine incidents. Health boards and trusts have pathways in place for learning from concerns. Quality and safety committees provide assurances to Boards that improvement actions are being taken. Some organisations also have learning bulletins to make sure that organisational wide learning takes place. One criticism from the review was that families who raised complaints did not always

know what remedial actions had been taken as a result of the concern being raised.

43. Health boards and trusts have developed "You said, we did" notices setting out what actions have been taken. For example, **Aneurin Bevan University Health Board** publishes examples of service improvements made as a result of patient experience feedback on their website as "You said, we did":

44. **Cwm Taf University Health Board's** natural waking initiative promotes choice for dementia patients and has led to a reduction in complaints and an increase in staff satisfaction.

45. **Public Health Wales NHS Trust** undertook an audit of the effectiveness of lessons learnt to determine if the lessons have been fully implemented to improve service and reduce the risk of reoccurrence. The audit found that learning is taking place and being implemented. One example is where bowel screening results are now offered face to face instead of by telephone messages.

46. NHS organisations are encouraged to triangulate information from complaints, concerns, compliments and patient experience feedback to develop a 'whole picture' of the organisation. As indicated above, the 'balancing' quadrant of the Framework for Assuring Service User Experience provides the qualitative source of feedback and can often be used to identify areas for service improvements. Patient stories are used at NHS organisation's Board meetings to link with a theme on the agenda and demonstrate the need for service improvements.

47. **Abertawe Bro Morgannwg University Health Board** produces patient experience feedback reports which triangulate complaints, incidents and family and friends results for Mental Health and Learning Disabilities and Primary and Community, Morriston, Neath Port Talbot, Singleton and Princess of Wales hospitals

Information and data

48. In order to learn from concerns it is important to be able to identify themes and trends. The Evans review felt that there should be better and more information in respect of complaints and concerns.

Dataset

49. In this regard a dataset was developed with participation from across NHS Wales. The dataset looks at both concerns and patient experience. One of the aims is to test the robustness of the complaints handling process. This dataset is currently being piloted with Abertawe Bro Morgannwg University Health Board, Betsi Cadwaladr University

Health Board and Velindre NHS Trust. The Welsh Government is also working with the office of the Public Services Ombudsman for Wales (PSOW). They are providing data on cases that come to them for referral as well as those that have a quick resolution or that the PSOW does not investigate at all.

50. All this information and data is to provide reassurance on the way complaints are being handled by health boards and trusts and will also include data around timeliness. It also helps to identify trends on a national basis. The data will also look at the compliments that NHS organisations receive to provide a rounded picture of the patient experience. The pilot will run until December 2016 and this will be put for approval to the Welsh Information Standards Board to allow the data to be captured on an all Wales basis going forward.

ICT infrastructure

51. One of the recommendations from the review was that the ICT infrastructure for recording concerns, incidents etc should be the same across Wales. At the moment, each organisation captures this information via their local risk management system. In Wales, all NHS organisations use the system of Datix. However, the platforms and modules that organisations use within Datix vary across Wales. Work has been undertaken to establish the infrastructure and contractual arrangements for each organisation. A project manager is currently being recruited to deliver this key piece of work which will also link with the development of a system to gather patient experience feedback across NHS Wales.

52. In the meantime, all NHS organisations are providing assurance to their local public by producing regular feedback on both concerns and patient experience. This information is scrutinised by their quality, experience and safety committees and made public via their websites. It is also contained within their Putting Things Right annual reports. Each organisation also has to produce and publish an Annual Quality Statement which provides an overview to the public on the work carried out to provide high quality services to its population and contains information regarding concerns as well as compliments.

53. **Velindre NHS Trust**'s Annual Quality Statement includes examples of service improvements made as a result of patient experience feedback.

PROMs and PREMs

54. Finally some early work has begun Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) and we will be able to provide a further update to the Committee in our next report.

Monitoring

55. The management of the concerns process is kept under constant scrutiny by a range of organisations.

Welsh Risk Pool

56. The Welsh Risk Pool undertakes an annual assessment of the way that health boards and trusts are handling concerns. They look at structures that support the PTR process and this year for the first time looked at informal concerns handling and primary care. Overall, the indication is that standards have improved marginally.

Public Service Ombudsman for Wales

57. The Public Services Ombudsman for Wales investigates concerns about NHS organisations where the complainant feels dissatisfied with the outcome of their complaint to the responsible organisation.
58. In 2015/16, health complaints accounted for 36 per cent of the Ombudsman's total caseload of 2,050 closed complaints compared to 34 per cent in 2014/2015. Of the complaints received by the PSOW only 16 per cent were upheld or partially upheld. Whilst there has been an increase in the number of referrals to the Ombudsman, the percentage of those upheld in full or in part is down by 2.8 per cent.
59. In 2015/16, the Ombudsman's office introduced improvement officers who will work with health boards and NHS trusts in Wales. This innovation will contribute to a whole systems approach to the sharing of best practice.

Community Health Councils

60. On a local level, local Community Health Councils provide advocacy services to those people needing support to raise concerns with health boards and NHS trusts. Since the Evans Review, the regulations governing Community Health Councils have been amended, giving the Board of CHCs in Wales new powers to set standards around the advocacy service provided by local Community Health Councils. The standards are currently out to public consultation.

61. In the last 12 months the Advocacy Service provided by Community Health Councils handled 1,528 new cases and closed 1,635 cases (includes cases opened before the reporting period).

Healthcare Inspectorate Wales

62. Healthcare Inspectorate Wales inspects NHS organisations in accordance with the Health and Care Standards. HIW's work is also informed by information gathered from a number of sources.

The future

63. The *Our Health, Our Health Service* Green Paper which was subject to consultation in 2015 looked at a number of areas which could impact on the way in which complaints and concerns are handled in the future. This included the role of Healthcare Inspectorate Wales, Community Health Councils and the potential for closer working with social care. Any proposals arising from this work will be subject to further consultation.