# The Royal Wolverhampton NHS Trust

## Trust Board Report

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| **Meeting Date:** | 27 January 2014 |
| **Title:** | Clwyd-Hart Report - A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture |
| **Executive Summary:** | The purpose of the report is to provide the Trust Board information about the above report and the RWT approach to date about the report. |
| **Action Requested:** | To note the contents of the report |
| **Report of:** | Chief Nursing Officer |
| **Author:**<br>**Contact Details:** | Jamie Emery, Patient Experience Lead<br>Tel 01902 695363 Email:jamieemery@nhs.net |
| **Resource Implications:** | None |
| **Public or Private:**<br>**(with reasons if private)** | Public Session |
| **References:**<br>**(eg from/to other committees)** | |
| **Appendices/**<br>**References/**<br>**Background Reading** | The report mentioned in the title field is available via the below link<br>http://goo.gl/SY6JFX |
| **NHS Constitution:**<br>**(How it impacts on any decision-making)** | In determining this matter, the Board should have regard to the Core principles contained in the Constitution of:<br>- Equality of treatment and access to services<br>- High standards of excellence and professionalism<br>- Service user preferences<br>- Cross community working<br>- Best Value<br>- Accountability through local influence and scrutiny |

## Background Details

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| **1** | **Introduction.**<br>The Clwyd-Hart report was published October 2013. The following paper provides a summary of the report, key recommendations for Trusts and the RWT approach to date. |

**A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture**

**October 2013**

**Right Honourable Ann Clwyd MP and Professor Tricia Hart**

***"The days of delay, deny and defend must end and hospitals must become open, learning organisations"***

**Ann Clwyd October 2013**

## i) Summary

The Clwyd-Hart review was commissioned by the government after the public inquiry into Mid Staffordshire and was published in October 2013. The report looks at how complaints about care in NHS hospitals made by patients, their carers and representatives are listened to and acted on by hospitals.

The recommendations cover

- improving the quality of care
- improving the way complaints are handled
- ensuring independence in the complaints procedures
- whistleblowing

Previously the Francis Report contained 14 recommendations about complaints handling. The Clwyd-Hart report echoes the needs around culture change from the highest level and transparency. The Clwyd-Hart report concurred with Francis around the use of independent investigation in certain circumstances, as detailed below:

- A complaint which amounts to a SUI.
- Clinically related issues not capable of resolution without an expert medical opinion.
- Misconduct or performance of senior managers.
- The nature and extent of services commissioned.

The review received 2,500 responses, the majority describing problems with the quality of treatment or care in NHS hospitals. The review panel also heard from people who had not complained because they felt the process was too confusing or they feared for their future care.

The review advocated that complaints must be taken seriously at the most senior levels, with Chief Executives responsible for signing complaints off and Trust Boards scrutinising and evaluating complaints.

The review also called for staff to be better equipped and trained to listen to patients, having the ability to deal with complaints, be they expressly stated or otherwise. This takes account of the numbers of people who may wish to complaint but who do not for various reasons, such as fear of recrimination or not wishing to be a nuisance.

A significant forerunner to the Clwyd-Hart report were comments aired in national media by Dame Julie Mellor of the PHSO. She also said that people often did not complain because they feared even worse treatment. Dame Julie said that those who suffered harm were often denied a simple apology.

***"What we found was that there is a toxic cocktail - patients felt reluctant to complain, because they can fear it will affect the care they get, and that if they do they are met with a culture of defensiveness where they don't get the explanations they need, and the opportunity is lost to learn really powerful insights which could improve the NHS."***

**Dame Julie Mellor, Parliamentary Health Service Ombudsman**
**August 2013**

### ii) Specific Recommendations/Actions for Trusts

The Clwyd-Hart report contains 38 points for action for Trusts and various other bodies. A summary of the key points for Trusts is provided below.

- Adequate training and supervision for staff, focussing on communication, customer services principles and complaints handling.
- Key information available to patients, relatives and carers locally, for example who is who on each ward.
- Introduce simpler ways of providing feedback, for example a pen and paper at each bedside.
- Volunteer support for complainants.
- Support for Boards and CEOs to have the necessary skills in communication and scrutinisation of patient feedback. CEOs to be personally responsible for complaints procedures.
- Board led scrutiny of complaints, including evaluation of the effectiveness of actions.
- Effective signposting for support available for patients.
- Honesty, openness; a willingness to listen and learn from complaints, appropriate professional behaviours.
- Ensure actions in complaint handling meet complainants' expectations.
- Fostering of a culture which embraces complaints as necessary to drive service improvements.
- Publication of annual complaints reports.
- Conversations from the outset with complainants to agree how complaints will be handled and timescales.
- Co-operation where complaints span other Trusts/organisations.
- Truly independent investigation where serious incidents are concerned.
- Assurance about the independence of clinical, lay advice and advocacy offered.
- Involvement of Healthwatch and local communities in complaints development.
- Board level complains scrutiny should involve lay representatives.
- A Board member with responsibility for whistle-blowing, regularly accessible to staff.
- A legal obligation to act of founded concerns raised by staff.

In conclusion the Clwyd-Hart report emphasises calls made through previous reviews for openness, honesty, transparency, culture change and for providing feedback to be made much easier; for patients, carers and relatives to be able to do this on their terms rather than those created by the NHS.

Dealing with complaints through formal routes in the NHS is a process. It is this process which can often be so attritional for complainants. Future work in this are needs to focus on the ease of making a complaint and changing culture to understand how RWT can improve this for complainants.

**Principles of dealing with complaints are relatively simple. Staff must listen, sympathise, agree a course of action and follow this through. Empowering all frontline staff to do this and to recognise and address dissatisfaction at source is a significant challenge. It will, as Clwyd-Hart stresses, make raising concerns much easier for patients and the public.**

### iii) RWT Response

The RWT Patient Experience Strategy for 2014 – 17 was agreed by the Trust Board in September 2013 and this strategy affirms the principles of The Clwyd-Hart report. It places emphasis on the importance our staff and our facilities have on patient experiences.

The Clwyd-Hart report is timely in the light of recent RWT feedback from the CQC advising that we must do more about publicising opportunities for patients and the public to give us feedback.

Ways of publicising complaints information, other sources of patient feedback information, also what has been done locally to improve patient experience have been introduced locally on wards. Ways of expanding how information and insights are collected and analysed has also been undertaken.

RWT will use the Clwyd/Hart report as a means to radically rethink how we address complaints in how we handle them, publicise opportunities to complain and how we prevent complaints. A task and finish group is being convened to look into innovative approaches to this important issue and take forward the plan around making the improvements advocated by the Clwyd-Hart report.

Terms of reference have been devised for the project and individuals selected on the basis of their suitability to help drive a new approach. Whilst these ToRs are important in establishing objectives the idea is for sessions to be a very informal and creative. An alternative type group membership is deliberately being recruited to the task so as to discourage usual solutions.

The RWT Strategy explains the importance that staff have in delivering the experience patients receive. It is therefore vital that RWT recruit the right people, set the expectations, give them adequate training and support them in delivering a positive experience.

Buildings, environment and access also have a profound effect on how patients receive care and how they feel about it. Recognising these important aspects of how we prevent complaints and improve experience is key moving forward and senior representative from Human Resources and Estates have therefore been asked to participate.

The Trust Board will be provided with further detail relating to the plans devised by the task and finish group.