Number: WG 51205

Welsh Government

Consultation – summary of response

Public consultation on the proposed changes to the Putting Things Right Process Response Report

December 2024

Mae’r ddogfen hon ar gael yn Gymraeg hefyd / This document is also available in Welsh
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg / We welcome correspondence and telephone calls in Welsh

Digital ISBN

Overview

The Welsh Government undertook a consultation on the proposed changes to the Putting Things Right process, seeking views on the way concerns and complaints about NHS care are raised, investigated, and responded to.

Action Required

This document is for information only.

Further information and related documents

Large print, Braille and alternative language versions of this document are available on request.

Contact details

For further information:

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Additional copies

This summary of response and copies of all the consultation documentation are published in electronic form only and can be accessed on the Welsh Government's website.

Link to the consultation documentation: hyperlink

Contents

Introduction and Background

Putting Things Right was introduced in 2011 to bring to the citizens of Wales a single process for raising a concern or complaint about NHS care in Wales and includes the investigation of patient safety incidents.

This was intended to provide an easy to access system to raise a concern and enable the immediate correction of things that have gone wrong, where possible, and, where that is not possible, the proper investigation of a concern; lessons learnt, and the sharing of information with the patient to demonstrate what action has been taken to prevent reoccurrence in the future.

Improving the Putting Things Right (PTR) NHS complaints system ultimately leads to a more responsive, effective, safer, and patient-centred NHS that listens to patients and families. This is achieved through meeting the new aims of PTR complaints system which are:

1) To enhance and improve patient care though listening and acting,
2) Promote an open and just culture,
3) Increase transparency and trust,
4) Prevent future harm,
5) Support staff development and learning,
6) Meet legal duties and ethical standards.

Listening to stakeholders and Listening to the Public:

We have been listening very carefully over the past few years to the lived experience of both those who have experienced care in the NHS and those that have responsibility for its provision. We have also listened carefully to those who have shared their experiences when they have raised concerns about their care and how they were treated.

We have listened to those who provide legal advice and settle these cases. Not all cases end up moving down a legal pathway but when serious harm has occurred, or where the relationship between the patient and the healthcare provider organisation has become strained, these sometimes end up in a legal situation and despite best efforts this can feel very adversarial in nature and hurtful.

We deliberately brought in to force the Organisational Duty of Candour making it incumbent on NHS organisations to be proactively open and transparent, when harm has occurred during the delivery of healthcare. We want to empower a whole system culture shift and coupled with the Duty of Quality we have challenged the NHS to make this substantial shift toward high quality safe care that is centred on the individual's needs. We are striving for greater accountability in the NHS and with Welsh Ministers to ensure that they both consider how each decision that is made impacts on the improvement of services to patients at every level.

We have now also brought together the key lessons from listening with the public and providers to change the PTR process and the following report outlines the results of the public consultation on those proposed changes.

The independent and objective Audit and Assurance Services (NHS Wales Shared Services Partnership) was commissioned to provide scientific methods and rigor to the analysis of the results. This included the use of an evidence-based framework (Reader and Gillespie 2014[1]) which was used to guide the initial analysis using both an inductive and deductive approach[2].

133 respondents took the time during the consultation to reflect on and share their often painful and sometimes difficult experiences of raising complaints relating to their care or that of a loved one. There was significant learning and a real demonstration through these shared experiences of just how much change is needed in our complaints system. This in conjunction with the consultation results, stakeholder workshops, the previous review (Evans Review 2014[3]) of PTR, recent inquiries and lessons from Scotland and England have helped form the evidence to reach the conclusions on what we need to change here in Wales.

We take this opportunity to express our sincere gratitude for the courage and candour of those who have shared their experiences in this consultation.

Consultation Details

The consultation on the proposed changes to the Putting Things Right process and the NHS (concerns, complaints, and redress) Wales Arrangements 2011 ran from 12 February to 6 May 2024 and following requests from stakeholders, was extended to 10 May 2024.

Responses to the consultation were received in numerous ways including:

- Online via the Smart Survey portal, submitting a hard copy via email, completing the easy read consultation document and submitting that by email and primarily responding by email

The consultation proposed these changes to the Putting Things Right process:

- To place patients at the heart of the process

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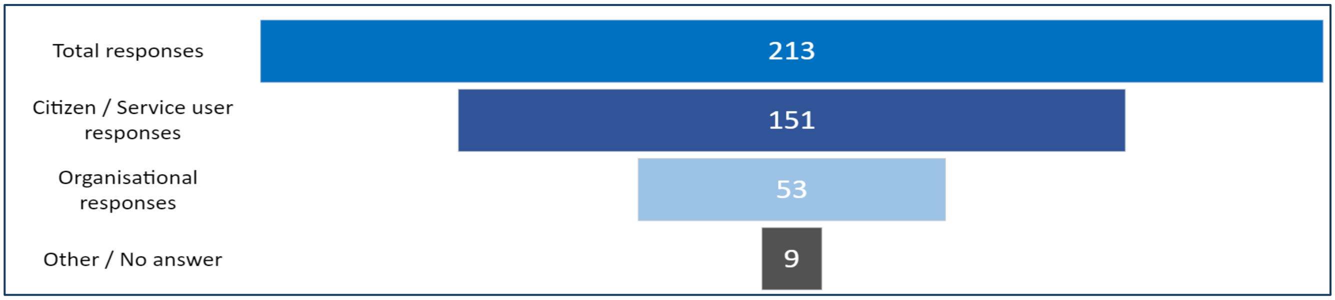
[1] Gillespie A, Reader TW. BMJ Quality and Safety 2016; 25: 937–946.

[2] **Inductive** reasoning involves making conclusions based on specific observations or patterns e.g. All the swans I have seen are white. **Conclusion**: All swans are white. **Deductive** reasoning involves drawing specific conclusions from general accepted facts e.g. **Facts**: All birds lay eggs and a penguin is a bird. **Conclusion**: penguins must lay eggs

[3] https://www.gov.wales/written-statement-review-concerns-complaints-handling-within-nhs-wales-using-gift-complaints-next#:~:text=Mr%20Evans%E2%80%99%20review%20concluded%20that%20Putting%20Things%20Right%2C,he%20highlighted%20variations%20in%20its%20implementation%20across%20Wales.

- To improve the focus on compassionate, patient-centred communication
- To improve the Putting Things Right process to be more inclusive
- To include an escalation process for urgent concerns of deliberate abuse or harm
- To provide answers after someone dies
- To refresh the arrangements to provide free legal advice and medical expert reports

Consultation Results



Graphic 1: Respondent overview and breakdown.

A total of 213 responses were received in response to the consultation, from a population in Wales of 3,132,000[4]. The analysis of these responses has been conducted with a 95% confidence level, which is a statistical measure that indicates how closely our sample estimates reflect the proportion of agreement in the entire population[5].

This information is crucial for making informed decisions. Public support based on the sample size and responses for the policy changes is likely between 74.63% and 85.37%.

However, it's important to note that there is a 7% margin of error. This means that the true value could be 7% higher or lower than our estimates. This is a relatively small error rate; good survey design would look to achieve between a 4% and 8% rate. It is still crucial to consider this when interpreting the results and making decisions based on this analysis. In conclusion, the responses we have received are a strong and accurate representation of the opinion of Welsh citizens and organisations involved in advocacy and care in Wales. All consultation documents were available on the following page: Proposed changes to the Putting Things Right process | GOV.WALES

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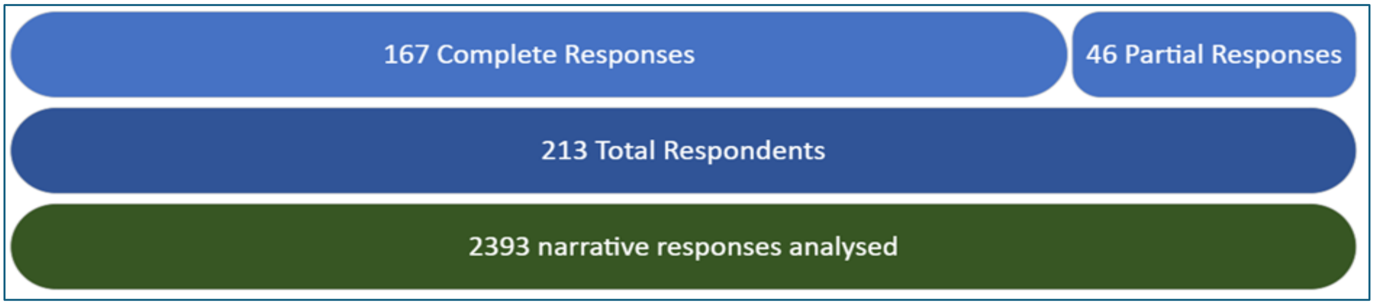
[4] Population estimates for the UK, England, Wales, Scotland, and Northern Ireland: mid-2022: Population estimates for the UK, England, Wales, Scotland, and Northern Ireland - Office for National Statistics (ons.gov.uk)

[5] The confidence interval is (0.7463) to (0.8537) This interval indicates that you are 95% confident that the true proportion of "yes" responses in the entire population lies between 74.63% and 85.37%.



Graphic 2: Respondent and comments provided overview.

Summary of responses by chapter

Your own experience

Question 1: If you would like to tell us about a concern or complaint you have raised about care received from NHS Wales, please do so below.

In total, 133 responses were received to the first question of the consultation, and we are hugely grateful to each person who took the time to share their personal and deeply moving experiences. Each story has been considered in detail on an individual basis, and we feel the experiences shared justify and underpin why changes are needed to the Putting Things Right process. The personal experiences shared as part of this question, and to question 25, are extremely powerful, informative, and important, and they have been listened to and reflected upon carefully.

A wide range of topics, concerns and issues are raised within the personal stories shared and, whilst careful attention and consideration has been given to each individual experience, some common themes have emerged, and these have been used to inform the consultation analysis. We felt that it was important to share the personal experiences outlined by respondents and have carefully selected below some extracts that we feel portray the sentiment and experiences some have been through. We have done this by grouping them into eight themes that will be used throughout the consultation analysis and whilst we recognise that this does not reflect all responses to questions 1 and 25, we hope that it gives the reader an insight into the experiences that have been conveyed within the responses

Communication

Definition: The respondent highlighted that there has been a communication breakdown, alternative communication methods should be considered, or patient-staff dialogue needs to be improved.

- "We raised a complaint about my father being prescribed an anti-psychotic drug by a care home without any consultation with family or his/power of attorneys. Numerous responses received which contradicted the replies from other agencies or were direct lies. Questions not answered. Family concerns not recorded. Complaint closed without any answers to questions asked due to the time it was taking for [Health Board redacted] to investigate.” (Anonymous respondent)

- There needs to be constant communication. People understand things take time but if you contact them to let them know their complaint is still being processed, it goes some way in making people feel respected, valued, heard and included. There also needs to be different methods of communication offered including email, written, phone, face to face, interpreters, easy read information etc. (All Wales Forum of Parents and Carers of People with Learning Disabilities)

- “Poor or absent communication was a constant theme. At the outset of interaction, complainants should be asked ‘how’ and in what format they would like to be contacted because of various access needs and preferences. Where telephone calls to complainants take place, a letter should automatically follow, reiterating the discussion so that the complainant has copies of everything for their records.” (Fair Treatment for the Women of Wales).

- "I believe there needs to be a consistent pattern of communication with complainants, that must sit within a wider culture of openness. I believe this becomes even more important when a complaint is taking a long time because in these circumstances the staff dealing with complaints can change, sometimes frequently. Casework experience also suggests that what I might describe as a form of triage is applied to complaints. Of course, this may well already happen but communicating that to complainants/caseworkers could help in the management of constituents' expectations.” (Dawn Bowden MS, Member for Merthyr Tydfil and Rhymney).

Compassion and Understanding

Definition: The respondent highlighted that communication needed to be compassionate, and professionals needed to take the time to understand concerns raised.

- “From first-hand experience and speaking with others, changes are desperately needed in relation to this throughout the whole of the NHS.
  Specifically in terms of ‘how’ people responded to a little compassion and human-like responses - they are possible whilst remaining professional and would go such a long way from the outset, particularly in heartbreaking cases.

  “Hollow copy and paste type responses are not constructive for complaints relating to ‘serious/catastrophic’ incidents and can potentially do further damage.

  “Accountability where appropriate from the outset is needed and a timely, meaningful apology for any specific, known failures (apologising for failures is not an admission of liability and is just the decent human thing to do as soon as failures are identified).

“In rare catastrophic cases, offering to meet in person with those affected needs to happen. In the rarest tragic cases a senior board member being visible would be helpful to those directly affected and demonstrate they are taking it seriously.” (Anonymous respondent)

- **“**My father died of hospital acquired Covid, it took over 2 years for my concerns to be dealt with and even then, i do not have the answers to my questions. The response from the [Services redacted] was insincere and disingenuous. All they are concerned about is covering up, whitewashing, and fail to answer the concerns put to them for fear of litigation” (Anonymous respondent).

- “The [Health Board redacted] took an unacceptable length of time to respond, and when it eventually came**,** the investigation report was cursory, impersonal and defensive.” (Fair Treatment for the Women of Wales).

- “My mother had an in hospital unexpected death. Plus we submitted a formal complaint surrounding care. No correspondence from the said Health board in thirteen months. Phone calls made to their concerns and complaints department and told someone would contact us. No response”. (Anonymous respondent)

Quality

Definition: The respondent highlighted poor treatment or quality of care in their response. Or felt that quality outcomes for the individual should be the aim of the proposal and process.

- “My sister was admitted to [Location redacted] with a non-trauma hip fracture on [Date redacted]. Forty-eight hours after presentation there was no plan to repair the fracture and her pain relief was inadequate. There were consistent issues throughout her stay in hospital. She sadly passed away on [Date redacted] two days after finally being transferred to [Location redacted]. A letter of complaint was sent to [Health Board redacted] on [Date redacted] but the complaint response was not issued until more than a year later on [Date redacted] shortly after Llais became involved on [Date redacted]. The response letter does not answer our questions adequately. Carefully worded answers have either avoided or missed the point The complaint was forwarded to the Ombudsman on [Date redacted] and is now being assessed by them.” (Individual, CW)

- “During the birth of my daughter my care was appalling and I’m only now realising how bad it was speaking to [Organisation redacted] and others and it’s set me and her back massively. I had a c section that I was in theatre for over 5 hours I went to intensive care and so did my daughter. I wasn’t told she was resuscitated until she was 7 days old, and I hadn’t even had skin to skin by then, she was premature and its massive [for] their development. The pain relief wore off twice in theatre and I didn’t even get to see my daughter before she was taken to NICU. It affected our bond and it added to my post-natal depression. In relation to birth injuries and the effects it has on you later on, 3 years isn’t enough to raise this as a complaint” (Individual, PR).

- “Lack of care my late husband received prior to his death. [He] had a persistent cough that started about [Date redacted]. The complaint is centred around the GP practice [Location redacted] and how they handled his case.” (Individual, MM)

- “I have made a complaint regarding my Wife’s death in July 2020. There were many failings during the period [Date redacted] while she was unwell. There were failings by both [Location redacted] and [Health Board redacted] when we made a total of four complaints which were ignored. Furthermore, during that period Doctors and Consultants commented to us acknowledging the poor care she had received but it seems there was no internal escalation to address the matter.” (Individual, SR)

Patient Focus

Definition: The respondent highlighted that the patient/individual and their rights should be at the centre of any decision, there needs to be additional support highlighted/put in place or the respondent underlines a negative patient experience.

- “Where Social Services and Health Board staff work together side by side, e.g. in an integrated CMHT [Community Mental Health Team] where both sides are bound by the 2010 Mental Health Measures (Wales), there should be one integrated complaints process. A mental health patient should not have to deal with the additional complexity and stress of making two complaints, with the scope of accountability being denied by both sides and getting "lost somewhere in the gap". (Anonymous respondent).

- “It is very difficult to be working with a 'putting things right process' when you are dealing with a death of a loved one, things could not be put right. I would suggest considering the framing of the process from the perspective of individual and family” (Anonymous respondent).

Safety

Definition: The respondent highlighted that there has been a safety incident, or concerns are raised about the skills and/or conduct of staff.

- “I sincerely hope something meaningful comes from this consultation. There is so much good work being undertaken within the NHS but from my personal experience of being at the heart of an internal 'serious incident' investigation into the preventable death [information redacted], the way in which my complaint (and others I have spoken to within the wider NHS) are dealt with lets the NHS, their staff and general public down. This really needs to be looked at in my opinion not only for future patient safety but for staff on the frontline too who are the ones that are required to stand up in the Coroner’s Court etc. and answer questions in catastrophic cases while those further at the ‘top’ within the hierarchy are often not visible at all.” (Anonymous respondent).

- “My mother in law walked into [Location redacted] in [Date redacted] and spent the next 12 weeks on various wards with inconsistent lead management and lack of day to day nursing care which resulted in her death on [Date redacted], she was then moved without prior consent or knowledge by the family to the [Location redacted], delays were also experienced with the issue of her interim death certificate” (Individual, KW).

Organisational Issues

Definition: The respondent highlighted organisational issues such as unsuitable/unclear guidance and processes, insufficient finances, staffing or resources.

- “It has been acknowledged, there were serious failings throughout, caused by both [Health service redacted] and [Health body redacted]. These delayed the care [Name redacted] received which put her at greater risk of serious illness and death. Nobody has considered the collective failings holistically or commented on the impact these had on [Name redacted] because there is no accountability for both Primary and Secondary Care. My complaint has been split and this only serves to lessen my allegation of negligence. They act totally independently despite being funded by the same source, run as the ‘NHS Wales’s and having intrinsically linked systems and processes which depend on one another.” (Individual, SR)

- “[It’s] not always clear what to do, I wrote a complaint to [the] NHS about my doctors but had a reply a few weeks later saying my surgery was privately owned so they couldn't help” (Age Connects Morgannwg).

Timing and Access

Definition: The respondent underlined an issue with timescales, delays or access to information or services.

- “I waited over 2 years for a surgery that was marked after a 10-day hospital stay as urgent and to be done within 2 weeks. I have now had my surgery but only after escalating a complaint” (Anonymous respondent).

- “Once inquests have taken place there should be a time limit on when health boards will provide a final response under PTR. It took the health board 7 months to write to us.
  So far, my brother's case has taken four years. The continual delays and failure to provide timely information (where we have had to request again and again via our solicitor) are a source of great distress to me and my family. Overall, it has been unacceptable and distressing. Apologising for delays is just not good enough and unacceptable.” (Individual, JM).

- “The Commissioner’s Advice and Assistance service often deals with issues of delays within the Putting Things Right complaints process. Often, multiple agencies are involved, such as safeguarding or the Medical Examiners Service (MES), and as a result of delays, the enquirer often runs out of time to proceed with their complaint.” (Older People’s Commissioner for Wales).

Continuous Improvement

Definition: The respondent felt that additional training is required or felt that lessons learnt should be considered to improve the service.

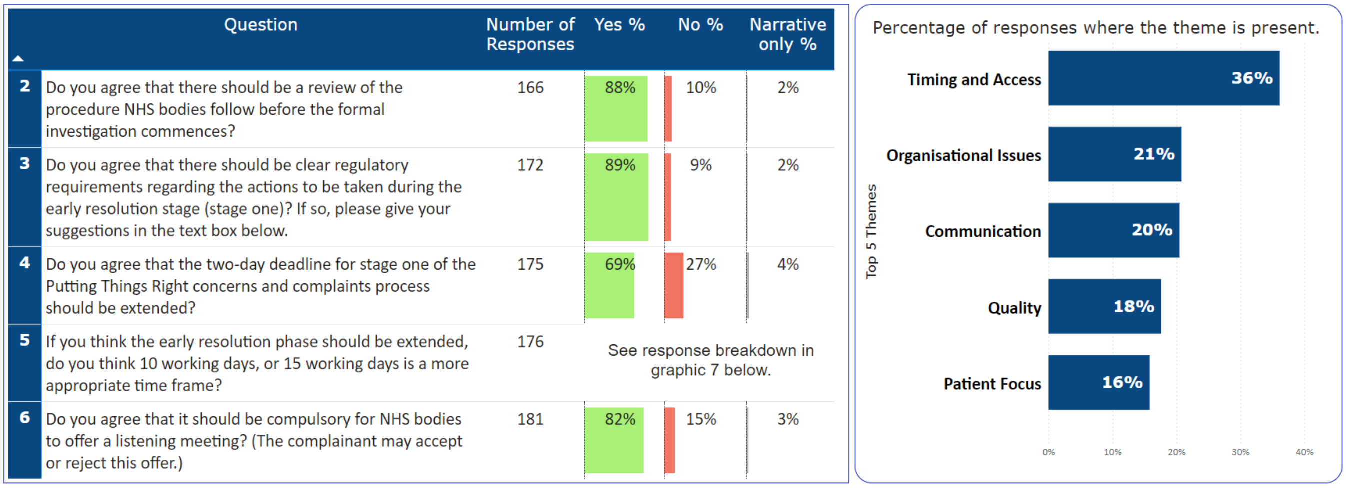
- “Discussions with our All-Wales Cancer Community steering group indicated that there is interest amongst cancer patients in establishing a formal route for providing positive feedback on particularly good care, if it can be used to help show examples of good practice” (Tenovus Cancer Care).

- “This is probably the fourth complaint I have raised regarding the care I have received from the [Location and organisation redacted] in the past 12 years. All I’ve received are apologise and nothing seem to change, and nothing is learnt” (Anonymous respondent).

- “There is a systemic culture in our Health Board of defensiveness. There is a complete inability for the majority of staff to receive constructive criticism or have their decisions questioned. When you do, they are met with defence and anger. They seriously need to change this culture and be open to reflect, develop and make positive changes. No one is perfect, mistakes happen, but there is a lot to be said for how it is handled” (Individual, JC).

- I have waited 8 months for one Health Board to agree a joint expert to investigate causation. I believe the "delay, deny, defend" manta is still alive and kicking” (Anonymous respondent).

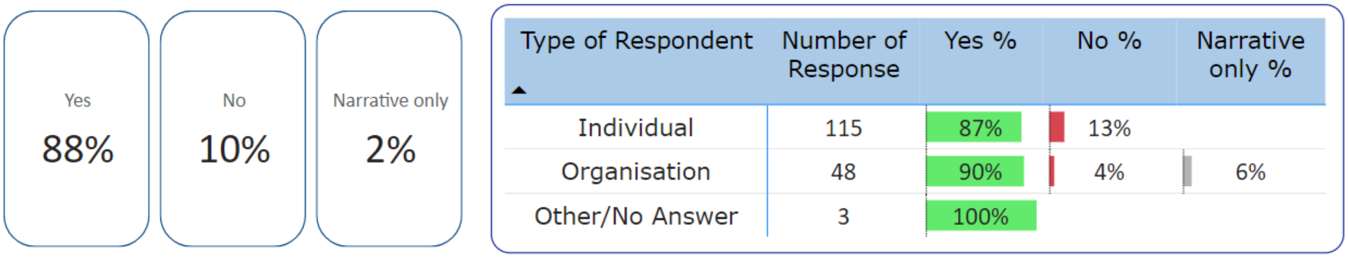
Stage one of the concerns and complaints process



	Question	Number of Responses	Yes %	No %	Narrative only %
2	Do you agree that there should be a review of the procedure NHS bodies follow before the formal investigation commences?	166	88%	10%	2%
3	Do you agree that there should be clear regulatory requirements regarding the actions to be taken during the early resolution stage (stage one)? If so, please give your suggestions in the text box below.	172	89%	9%	2%
4	Do you agree that the two-day deadline for stage one of the Putting Things Right concerns and complaints process should be extended?	175	69%	27%	4%
5	If you think the early resolution phase should be extended, do you think 10 working days, or 15 working days is a more appropriate time frame?	176	See response breakdown in graphic 7 below.		
6	Do you agree that it should be compulsory for NHS bodies to offer a listening meeting? (The complainant may accept or reject this offer.)	181	82%	15%	3%

Graphic 3: Theme and response summary of 'Stage one of the concerns and complaints process'.

Question 2: Do you agree that there should be a review of the procedure NHS bodies follow before the formal investigation commences?



Yes	No	Narrative only
88%	10%	2%

Type of Respondent	Number of Response	Yes %	No %	Narrative only %
Individual	115	87%	13%	
Organisation	48	90%	4%	6%
Other/No Answer	3	100%		

Graphic 4: Question 2 response and respondent overview.

46% of responses to this question cited timing and access within their feedback, with many highlighting that the current 2-day deadline for early resolution is an insufficient amount of time for the informal process and in some cases, it was highlighted that this was unachievable. Many respondents felt that early resolution would be the best outcome for individuals, and others highlighted that not all complaints warrant a formal investigation. It was suggested that by having the current 2-day deadline, some complaints were moved into the formal stage unnecessarily, and sometimes against the wishes of the complainant. Feedback such as this, resulted in 19% of comments highlighting the need to be more patient focused, with comments underlining that the complainants' views and feelings should be at the centre of the process.

"It is concerning that the current system can mean complaints automatically move into the formal stage regardless of the patient's wishes and we believe this should be reformed such that the patient's views and wishes where possible remain central to the process. Reform could lead to more issues being resolved at Stage 1 to the patient's satisfaction." (The Royal College of Physicians of Edinburgh)

"Where possible, concerns and complaints would ideally be resolved early without a formal investigation being required. However, we recognise that limiting the opportunity for this to take place to just two working days can mean that complaints may escalate unnecessarily, where they could potentially be resolved with a little more time. BMA Cymru Wales would therefore support a review to allow for a longer deadline, provided the seriousness of the complaint is appropriate for stage one resolution." (British Medical Association Cymru Wales)

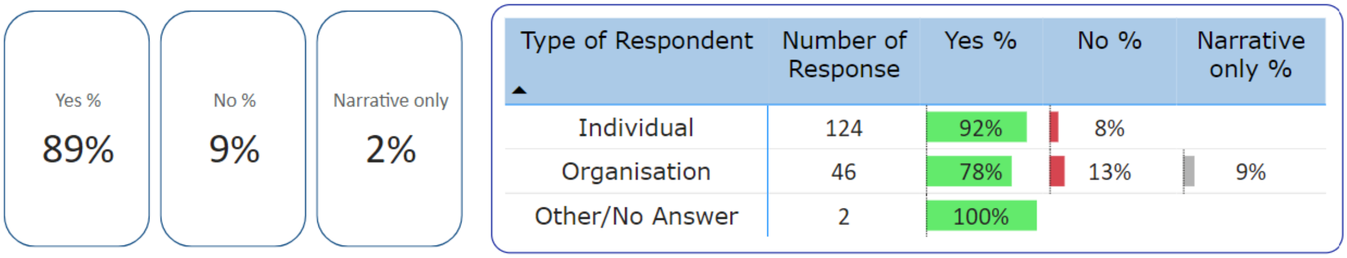
It was highlighted multiple times that the current process is unclear and difficult to understand for the complainant. In addition, 17% of responses highlighted communication was an issue and that during the complaints process they were unaware of what stage they were at and what were the next steps.

"If someone was able and willing to spend some time explaining the process with us and the rationale behind decisions made it may have prevented a complaint being raised" (Individual, NHM).

Welsh Government Response to question 2.

Welsh Government commits to reviewing the procedure NHS bodies should undertake prior to formal investigation is started with a distinct redesign of the system to be more patient focused, placing the emphasis on the complainants' views and wishes being at the centre of the process.

Question 3: Do you agree that there should be clear regulatory requirements regarding the actions to be taken during the early resolution stage (stage one)?



Yes %	No %	Narrative only
89%	9%	2%

Type of Respondent ▲	Number of Response	Yes %	No %	Narrative only %
Individual	124	92%	8%	
Organisation	46	78%	13%	9%
Other/No Answer	2	100%		

Graphic 5: Question 3 response and respondent overview.

14 respondents disagreed with adding more regulations and some felt it may cause further issues. They felt the introduction of further mandatory steps could increase the time it takes to manage early resolutions, and that new regulations may be inappropriate given this is an informal process.

"It needs explanation and understanding at [the] first stage not a legal process. Often people just need information and contact with those involved" (Penyrheol Trecenydd and Energlyn Community Council).

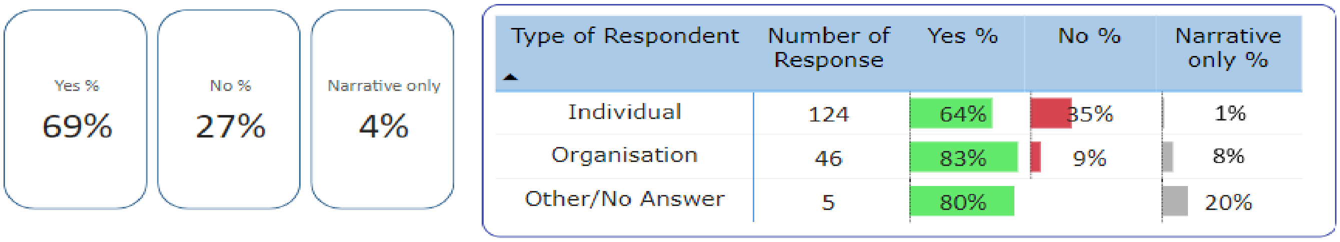
Respondents that agreed with the proposal consistently cited the importance of managing the expectations of timescales, ensuring that the process and guidance is clearly outlined, and this information is available to the complainant from the outset. To support this, it was highlighted that there needs to be clear communication, in an accessible and understandable format.

"A clear process and patient understanding of where they are in the process would ease concerns where lack of communication is a key problem in care received" (Anonymous respondent).

Welsh Government response to question 3.

Welsh Government will consider the introduction of a specific regulation to outline the steps to be taken during the early resolution stage. The intention here is to ensure that the components of the early resolution stage are protected but that any regulation is proportionate and not onerous or complex.

Question 4: Do you agree that the two-day deadline for stage one of the Putting Things Right concerns and complaints process should be extended?



Yes %	No %	Narrative only
69%	27%	4%

Type of Respondent	Number of Response	Yes %	No %	Narrative only %
Individual	124	64%	35%	1%
Organisation	46	83%	9%	8%
Other/No Answer	5	80%		20%

Graphic 6: Question 4 response and respondent overview.

There was a contrast in the support for this proposal, depending on the type of respondent being an individual or those who responded on behalf of an organisation.

<u>Respondents that answered ‘No’ to question 4:</u>

28% highlighted timing and access as a reason for disagreeing with the proposal. Multiple respondents felt that 2 days is enough time and that by extending the deadline it will only benefit the organisation and cause further delays for the complainants. Individuals in this group outlined:

“There are too many delays … People need to take responsibility when things go wrong and address and solve them in a timely manner” <u>(Anonymous respondent).</u>

“Complaints need to be listened to and actioned swiftly to identify poor practice and prevent issues for other patients and improve patient care” <u>(Anonymous respondent).</u>

21% highlighted an organisational issue for disagreeing with the proposal. This group underlined concerns with how their own complaints had been dealt with in the past, others felt that resources should be available to provide a response within the two-day deadline, and some highlighted general concerns with the NHS in Wales.

One suggestion highlighted; “I think 2 working days for a holding response. I would say 5 working days to give them an opportunity to investigate / initiate and reply outlining clearly what’s happening” <u>(Individual, JC)</u> and this suggestion was reiterated in multiple other responses to this question.

However, it was also highlighted that two days for acknowledgement is already included within the guidance; this would suggest that it is not currently being adhered to, or many people do not know this. If this timeframe were to be increased, the following statement may need to be considered, “The period for acknowledging receipt of the concern should [not] be extended beyond the current two-day period without consideration as to how this [would] dovetail with the period for suspension of limitation provided for under Regulation 45” <u>(Hugh James).</u>

Age Connects Morgannwg suggested; “As a charity we would also support a 'stop the clock' mechanism here if [the] patient/relative (but not staff) availability delays the process beyond the 2 days” (Age Connects Morgannwg).

Respondents that answered ‘Yes’ to question 4:

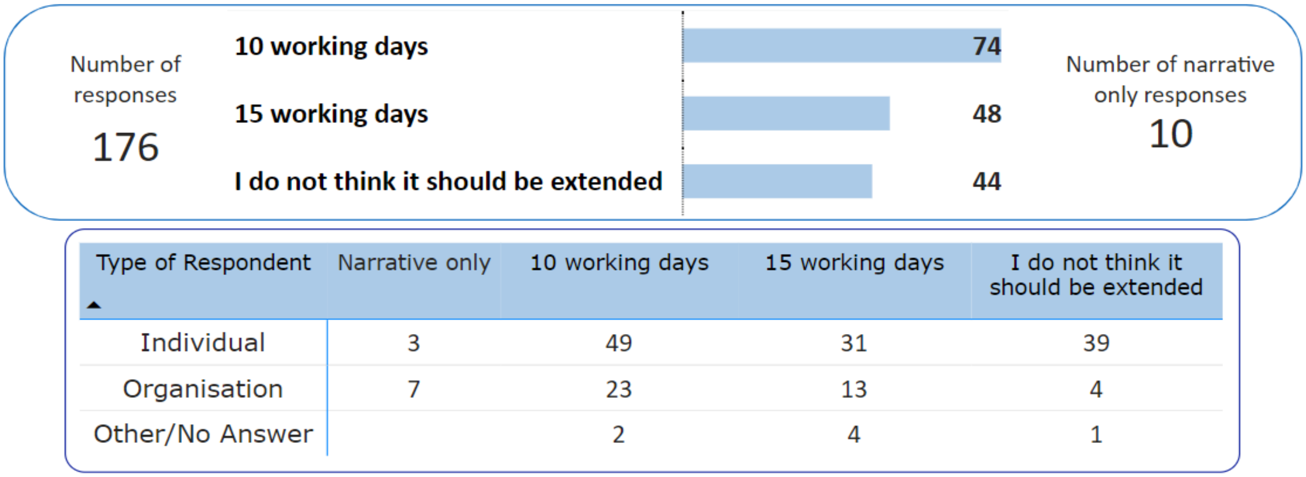
Although this question resulted in one of the biggest disparities in responses throughout the consultation, the majority did agree with the proposal to extend the two-day deadline. Points around timing and access, and timescales were prevalent in 44% of responses. Respondents highlighted consistently that 2 days is not long enough, and the current deadline is frequently missed so should be extended. One organisational response described that “shift patterns and operational pressures frequently render the process unachievable in 2 days” (Welsh Ambulance Services University NHS Trust). Respondents also felt that by extending the deadline, complaints can be given sufficient consideration rather than being rushed and leading to an unsatisfactory outcome for the complainant.

“An extension will ensure more robust and meaningful responses and would give health bodies more time to review the concern and complaint and possibly result in an increase of concerns and complaints being resolved at stage one, the early resolution stage. Moreover, it would allow busy clinical teams appropriate opportunity to review and engage with people who have raised the complaint” (The Welsh NHS Confederation).

Welsh Government response to Q4.

The current regulations require a written confirmation of receipt of the concern or complaint within 5 working days. This was updated in line with the introduction of the Duty of Candour in 2023 to match the written notification timeframe requirement under that duty. There is no plan to change this confirmation of receipt timeframe, but Welsh Government proposes to extend the two-day deadline for early resolution, which comprises of 1 working day after the day of notification, to allow for the early resolution phase to be completed.

Question 5: If you think the early resolution phase should be extended, do you think 10 working days, or 15 working days is a more appropriate time frame?



Type of Respondent	Narrative only	10 working days	15 working days	I do not think it should be extended
Individual	3	49	31	39
Organisation	7	23	13	4
Other/No Answer		2	4	1

Graphic 7: Question 5 response and respondent overview.

I do not think it should be extended:

Responses in this group reiterated their comments in question 4. With much of the feedback underlining that individuals would like their complaint to be dealt with as quickly as possible and that by extending the timeframe it is benefiting the organisation rather than the individual.

10 working days:

The respondents that answered 10 days to this question consistently highlighted that this would be "a sufficient period of time to establish [whether] or not a concern can be dealt with within the informal stage" (Thompsons Solicitors). There were respondents within this group that felt the consultation should have provided an option to extend the early resolution stage to 5 days, however many felt that 15 days would be too long as it could encourage complacency. It was suggested by one respondent that "At the outset of a complaint, the family should be provided with a guideline on when they will receive a full response, to manage expectations and contact details of someone should deadlines not be met" (Society of Clinical Injury Lawyers).

15 working days:

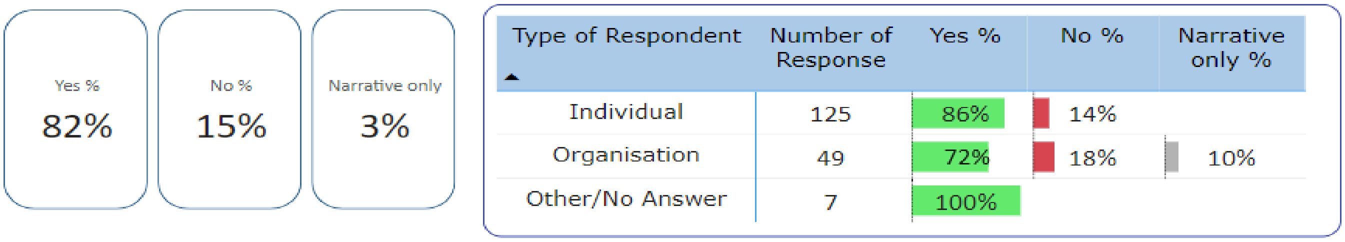
The respondents that answered 15 days to this question underlined that this would provide enough time to investigate the concern or complaint sufficiently, which would provide the best outcome for the complainant.

It is also highlighted multiple times that 15 days would ensure that staff availability and capacity should not be an issue during the early resolution phase and ensure that all the required attendees are available to meet with the complainant. "Given the challenges of staffing levels and staff availability (for those involved to aim for an early resolution)- the extended time would be of assistance" (Hywel Dda University Health Board).

Welsh Government response to Q5.

There were much more mixed responses in response to this question. The overall majority of 69% of respondents were in favour of extending and 25% did not want any extension to the early resolution (ER) stage. Of those who were in favour of an extension, 42% indicated 10-day and 27% indicated a 15-day preference. Welsh Government will proceed with implementing a 10-day extension to the ER stage which is aimed at facilitating opportunities for improved explanation and information giving and compassionate support and communication. It also will enable the mobilisation of advocacy if required to support in meetings which may be focused on resolving the complaints or answering questions and concerns.

Question 6: Do you agree that it should be compulsory for NHS bodies to offer a listening meeting? (The complainant may accept or reject this offer).



Yes %	No %	Narrative only
82%	15%	3%

Type of Respondent	Number of Response	Yes %	No %	Narrative only %
Individual	125	86%	14%	
Organisation	49	72%	18%	10%
Other/No Answer	7	100%		

Graphic 8: Question 6 response and respondent overview.

<u>Respondents that answered ‘No’ to question 6:</u>

26 respondents disagreed with this proposal, 52% of their comments contained references to communication and 21% referenced a need for patient focus. Some of these comments were interlinked with respondents feeling the method of communication should be the choice of the complainant.

Others highlighted the “response needs to be proportionate to the complaint” <u>(Anonymous respondent)</u> and this point was reiterated by another respondent that felt although the listening meeting should be offered 90% of the time, there are times it would be a waste of resources, and this should be identified by the complaints team early in the process.

In addition, respondents also highlighted there could be issues with staffing and resources when offering the listening meetings. One respondent highlighted that “the capacity, if all complainants expected a meeting, could be overwhelming for the services who are very busy anyway” <u>(Betsi Cadwaladr University Health Board)</u>. Numerous respondents reiterated that the volume of meetings may exceed capacity if the proposal is implemented: “This is great and gold standard in theory, but when the Quality & Safety Teams are currently struggling to respond via a written response within the prescribed timescales and hold meetings following the complaint to discuss the content, the extra resource required to do this will be substantial” (Swansea Bay University Health Board).

Respondents that answered ‘Yes’ to question 6:

Respondents in this group underlined that the implementation of the proposal would be key to improving communication, compassion and understanding.

“The initial response letters are very formal copy and paste letters. It is possible to respond with more compassion without compromising professionalism” (Individual, GR). It was underlined multiple times that each patient is important and should have their views heard throughout the process.

Many respondents highlighted that the offer and availability of patient support would be an important aspect of the meetings, and many felt this should come in the form of an advocate. Learning Disability Wales stated that; “there should be a statutory obligation on those NHS bodies to offer the opportunity for patients to bring an advocate or supporter to provide independent support” (Learning Disability Wales).

This was a statement supported by the Children’s Commissioner for Wales “close consideration should be given here to offering independent advocacy for accompanying children and young people to their listening meeting” (Children’s Commissioner for Wales). Another point raised in response to this question was that “Those raising the concern or complaint would also like to see some acknowledgement in communications that it may be very emotionally draining and worrying for complainants to attend. They would like to have an opportunity to address any concerns about attendance before the meeting” (Llais).

Welsh Government response to Q6.

Welsh Government recognises the concerns raised with this proposal. These are mostly about the resource requirements needed to ensure that if a mandatory offer was brought in to hold a listening meeting. Since the consultation several stakeholders in the NHS have discussed at length the issues this proposal may bring. Resources are a valid consideration that needs to be weighed carefully before deciding to move forward with this recommendation.

The Listening Meeting is an offer to meet virtually via video link, or by telephone and not necessarily face to face unless that is the preferred medium to support accessibility needs or for instance where it is felt to be more appropriate, such as meeting with a bereaved family. Many NHS organisations already reach out by telephone to someone who has raised a complaint and discuss with them the content of the complaint and what it is that needs answering or investigating and tell them how they are going to investigate it.

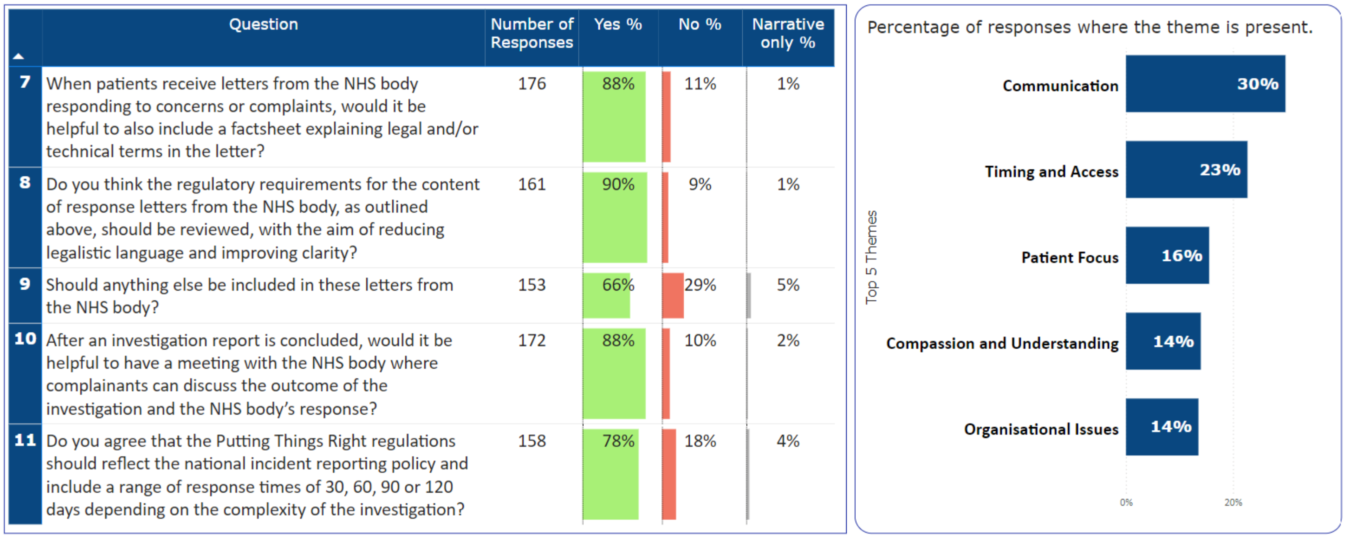
The change that is proposed is that this call or meeting is organised so that the person has the opportunity to arrange for another family member or professional advocate to be there to support them. It also allows them to prepare what they want to say in advance rather than responding to an unplanned call where the person may not remember to say everything they want to say. The focus of this call or meeting is to listen to the complaint or concern being raised. To enable the organisation to understand what is required in terms of realistic resolution. The majority may be dealt with swiftly in a ‘Listen and Act’ manner of early resolution. This may be for instance to meet with the clinicians at another time and have their questions answered and an apology for what was raised in the complaint. For more complex complaints where harm has occurred and liability may need to be considered clarifying exactly what is in the complaint, understanding the resolution required and being able to discuss realistic time frames for investigations and responses would be afforded.

It is clear that many respondents highlight a feeling of not being heard, of not being listened to and not getting the answers to their complaint when they receive the response many months later.

It is also clear that across Wales early resolution is already an effective tool in place for complaints for Primary Care general practice. In the past 3 years, of the hundreds of complaints received from patients, only a handful progress to redress or claims as they were met by the GP and listened to, apologies given, and their complaint was resolved to their satisfaction. This demonstration of openness and accountability is functional and effective. GP practices have even fewer resources compared to Health Boards but of course deal with fewer complaints. It should also be recognised that many patients do not want to raise a formal complaint but to be heard and to have their concern dealt with swiftly.

The Welsh Government will follow this example to maximise the use of the early resolution approach so successfully used here. We therefore will take forward the proposal for a listening meeting to be offered to support the facilitation of early resolution where this approach is appropriate across the NHS.

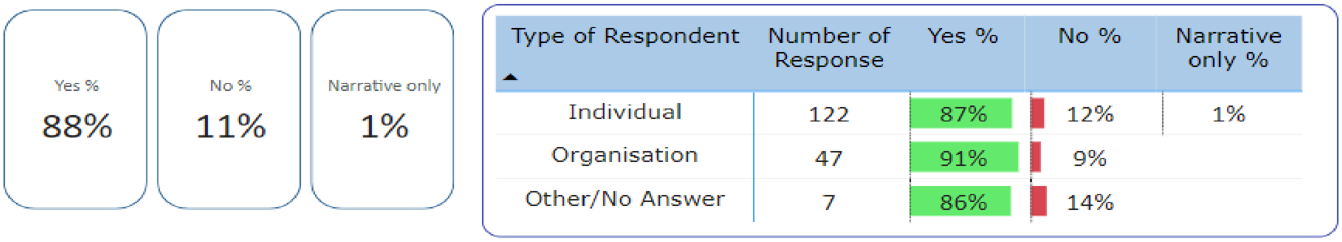
Improved communication in complaint handling



	Question	Number of Responses	Yes %	No %	Narrative only %
7	When patients receive letters from the NHS body responding to concerns or complaints, would it be helpful to also include a factsheet explaining legal and/or technical terms in the letter?	176	88%	11%	1%
8	Do you think the regulatory requirements for the content of response letters from the NHS body, as outlined above, should be reviewed, with the aim of reducing legalistic language and improving clarity?	161	90%	9%	1%
9	Should anything else be included in these letters from the NHS body?	153	66%	29%	5%
10	After an investigation report is concluded, would it be helpful to have a meeting with the NHS body where complainants can discuss the outcome of the investigation and the NHS body's response?	172	88%	10%	2%
11	Do you agree that the Putting Things Right regulations should reflect the national incident reporting policy and include a range of response times of 30, 60, 90 or 120 days depending on the complexity of the investigation?	158	78%	18%	4%

Graphic 9: Theme and response summary of chapter 'Improved communication in complaint handling'.

Question 7: When patients receive letters from the NHS body responding to concerns or complaints, would it be helpful to also include a factsheet explaining legal and/or technical terms in the letter?



Yes %	No %	Narrative only
88%	11%	1%

Type of Respondent	Number of Response	Yes %	No %	Narrative only %
Individual	122	87%	12%	1%
Organisation	47	91%	9%	
Other/No Answer	7	86%	14%	

Graphic 10: Question 7 response and respondent overview.

44% of feedback for this question underlined the need for effective communication to support the individuals' understanding and their ability to make informed decisions.

This point was repeated throughout the responses, and it was felt that the letters should be written clearly, without jargon, with easy-to-understand terminology.

"Simplify the terminology used in the letter. Does legal and technical terminology need to be used when communicating with the complainant. Whilst it may be used in the formal report, the letter should be focused on the reader and appropriate language used" (Individual, SD).

A small number of respondents that disagreed with the proposal highlighted that if this was a mandatory requirement it may cause issues for smaller organisations, in terms of their processes and resources.

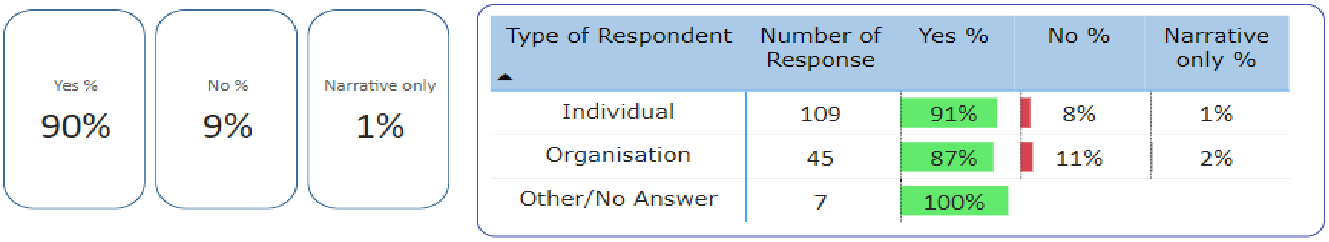
Although many answerers to this question felt that the letter should be simplified, there is a consensus that the factsheet would be helpful and support understanding.

“The factsheet should be co-produced with patients and carers to ensure it will have the desired affect” (Carers Wales) and Llais suggested that the factsheet or FAQs should be clearly signposted, visual aids could be used and also that their complaints advocacy service should be highlighted.

Welsh Government response to Q7.

Welsh Government will work with key stakeholders including some patient groups to develop a factsheet to aid better communication and understanding and move towards enabling the reduction of legal and technical terms in letters to complainants.

Question 8: Do you think the regulatory requirements for the content of response letters from the NHS body, as outlined above, should be reviewed, with the aim of reducing legalistic language and improving clarity?



Yes %	No %	Narrative only
90%	9%	1%

Type of Respondent	Number of Response	Yes %	No %	Narrative only %
Individual	109	91%	8%	1%
Organisation	45	87%	11%	2%
Other/No Answer	7	100%		

Graphic 11: Question 8 response and respondent overview.

The responses to this question reflect and reiterate responses to question 7. With feedback underlining that information should be easy for the complainant to understand and interpret. “The requirements to include [Public Services Ombudsman for Wales] (PSOW) information and terms such as breach of duty, qualifying liability[6], causes significant issues for the complainant, as feedback from patients, is that it appears, the organisation is avoiding legal cases rather than providing compassionate and caring response” (Betsi Cadwaladr University Health Board).

Once again, multiple respondents highlighted that the letters should be compassionate and person centric as this is what they currently lack.

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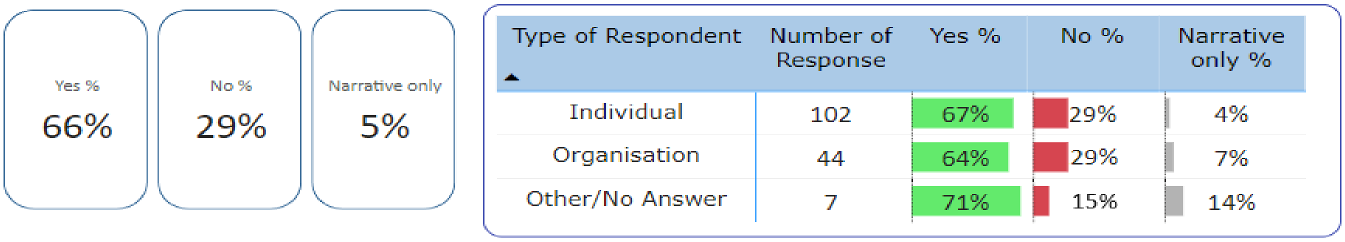
[6] (Qualifying Liability is understood to mean where someone breaches their duty of care to a patient, by failing to act according to the standards of a reasonably competent person, and this failure results in or causes the personal injury or loss)

Welsh Government response to Q8.

Welsh Government will work on reforming the regulations that specify the content of the response letters to complainants, where possible, and also be clearer in the PTR guidance that the content of the letters must contain language that is aimed at improving communication and understanding and move towards enabling the reduction of legal and technical terms in letters to complainants. This may consist of amending the required content in conjunction with Q7 response and require NHS bodies to ensure that complex terms are explained and consideration to accessibility needs is included as well as type of language used.

Question 9: Should anything else be included in these letters from the NHS body?



Yes %	No %	Narrative only
66%	29%	5%

Type of Respondent	Number of Response	Yes %	No %	Narrative only %
Individual	102	67%	29%	4%
Organisation	44	64%	29%	7%
Other/No Answer	7	71%	15%	14%

Graphic 12: Question 9 response and respondent overview.

Four topics arose consistently in response to this question: communication, organisational issues, timing and access and patient focus.

37% of comments reiterated the points made in question’s 7 and 8 around effective communication, and the importance of the letter being clear and easy to understand. In addition, 12% of responses suggested that the letter should underline a point of contact for the complainant:

“A nominated contact point and person. A caseworker who will liaise directly with complainant. To assist the progress of the complaint and assist understanding, offering guidance and creating reassurance” (Penyrheol Trecenydd and Energlyn Community Council).

Furthermore, comments regarding being more patient centred are present in 20% of feedback, and many respondents felt that the support available for complainants needs to be highlighted within the letter. It is highlighted multiple times that the services of Llais, and the Public Services Ombudsman for Wales should be signposted, and one respondent indicated that by highlighting further support available to individuals within the letters, it will help to make them appear more person centred; “additional resources around further support which depend on what the issue is. By doing this the letters will feel more person-centred and individual. From discussions with service users, many feel like just a number” (Anonymous respondent).

25% of comments highlighted the need to improve the current system, which is confusing and poorly organised, and that the letter should clearly outline for complainants where they are in the Putting Things Right process. Many responses also highlighted that next steps and escalation routes should be defined:

“The letters should clearly outline the escalation process of complaints including what stage you are at and what has been done so far. This can be relayed as simply as in a graphic flow chart” (Anonymous respondent).

Strongly linked to the need for better guidance and processes were comments relating to timing and access. Some respondents felt that the complainant should be able to access their own or family’s information, and copies of records should be included if it brings clarity. Others stated that there needed to be clearly outlined timescales so that:

“Complainants ... know what to expect and who to contact if there is no response forthcoming” (Individual, MM) and “a realistic timeframe of what somebody can expect during the process of a complaint such as when they will next [hear] from somebody” (All Wales Forum of Parents and Carers of People with Learning Disabilities).

Finally, another point that was made multiple times was the need for continuous improvement. Respondents indicated that the letter should include clear learning outcomes, highlighting what actions have been taken in response to the complaint so that there is “reassurance to the complainant that steps have been taken to stop a recurrence.” (Individual, KJ).

Welsh Government response to Q9.

The key message here appears to be that, in these respondents’ experiences, there is a need to improve practice across the NHS in terms of ensuring required information is included within any letters of response, and in other communications, in line with the existing regulations.

We have discussed with stakeholders why patients and families are not being offered a meeting to discuss the report findings (by phone or in person) or having the investigation report shared with them or the medical records unless they initiate this request themselves. The regulations currently require that persons raising concerns should already be kept involved in the process and abreast of times frames and any delays and that they should have one person allocated to oversee their case. Stakeholders report back a number of factors influencing the current variation in practice. These included knowledge and awareness of current practice, resources including timeframe compliance, and recognised a need to improve.

Welsh Government response to Q9 continued.

There was some disagreement amongst stakeholders as to the appropriateness of this offer and need to share in every case and that a more flexible approach should be considered, and this was best decided it was asserted by the NHS organisation. Welsh Government considers the complainant needs to be part of this decision if a flexible approach were to be adopted.

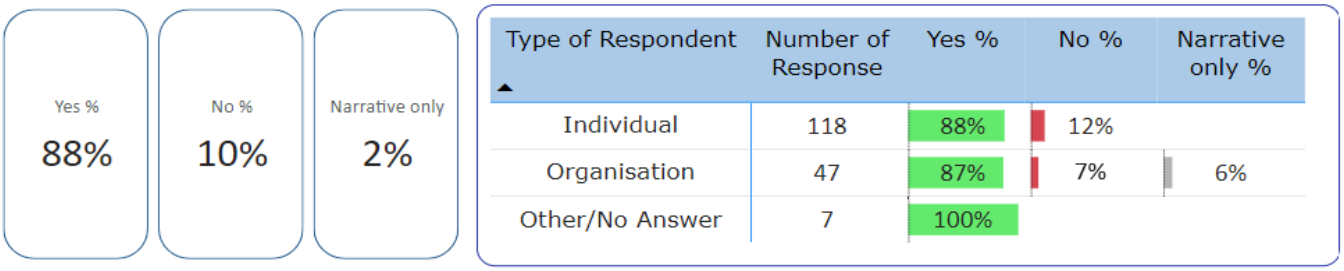
We will review the existing regulations and guidance on content of response reports and letters and also review the oversight responsibilities and monitoring of effective compliance with the regulations in terms of the content and quality of the responses to complainants. It is considered that the proposed greater focus on the early resolution Listen and Act approach will reduce the need to complete in depth investigations and complicated responses in a many cases which will in turn release resource to better manage the stage 2 of complaints and the investigations for patient safety incidents.

We will review the required content of letters to include these suggestions where appropriate if they are not already specified.

We will consider amending the regulations to allow the NHS body to follow the expressed wishes of a person who raised a complaint to not communicate the outcome of assessment of qualifying liability, or an offer of redress, where they do not want it communicated to them.

Qualifying Liability is understood to mean where someone breaches their duty of care to a patient, by failing to act according to the standards of a reasonably competent person, and this failure results in or causes the personal injury or loss)

Question 10: After an investigation report is concluded, would it be helpful to have a meeting with the NHS body where complainants can discuss the outcome of the investigation and the NHS body's response?



Yes %
88%

No %
10%

Narrative only
2%

Type of Respondent	Number of Response	Yes %	No %	Narrative only %
Individual	118	88%	12%	
Organisation	47	87%	7%	6%
Other/No Answer	7	100%		

Graphic 13: Question 10 response and respondent overview.

Many respondents felt that a meeting following the investigation report would provide the complainant the opportunity to ask any further questions to attain clarity and is also in line with being open and transparent and continues to put the person at the centre of the process.

"Consistent engagement with health boards will improve services and patient experiences" (Anonymous respondent).

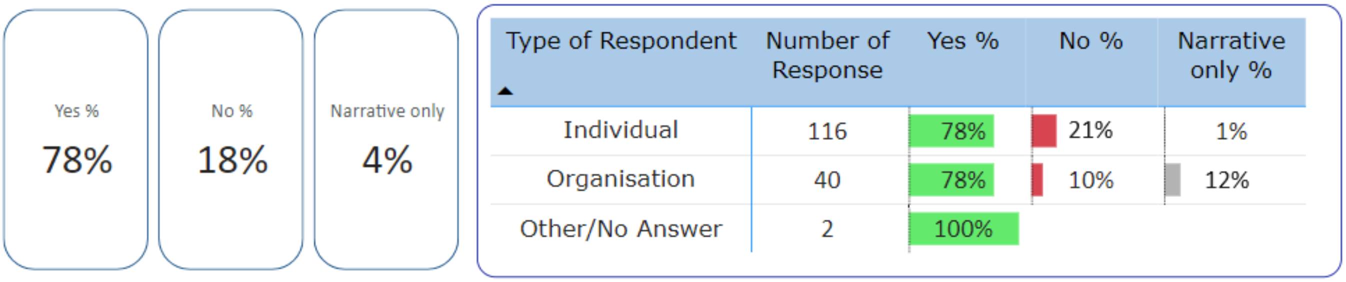
Respondents indicated that there should be a focus on providing quality outcomes for the individuals and the offer of this meeting would provide complainants with the chance to attain answers, discuss the outcome of the investigation and remove any potential ambiguity, as this is important for closure. As highlighted in the response to questions 6 and 7, respondents also highlighted that support for complainants should be made available and it should be outlined that they are able to bring an advocate to these meetings.

10% disagreed with the proposal, and some felt that all the information and full details of the investigation should be provided in the letter and report, others felt that it may not be appropriate to meet with the complainant at this point. One concern raised by a small group of respondents, irrespective of whether they answered 'Yes' or 'No' is that resources and staffing will need to be in place to hold these meetings. It was also suggested throughout responses that the format of the meeting may need to be considered and complainants should be offered multiple options other than just a meeting face-to-face, for example, over the telephone, or video call.

Welsh Government response to Q10.

A mandatory offer to discuss already exists in Regulations 24 and 26 but WG will now review the nature of these regulations and consider clarifying the requirement further in guidance and extending this offer to discuss to regulation 31. There is a clear and strong indication by a number of respondents that this could be advantageous however WG also recognises the sensitivity needed dependent on timing for those who are bereaved and their families.

Question 11: Do you agree that the Putting Things Right regulations should reflect the national incident reporting policy and include a range of response times of 30, 60, 90 or 120 days depending on the complexity of the investigation?



Yes %	No %	Narrative only
78%	18%	4%

Type of Respondent	Number of Response	Yes %	No %	Narrative only %
Individual	116	78%	21%	1%
Organisation	40	78%	10%	12%
Other/No Answer	2	100%		

Graphic 14: Question 11 response and respondent overview.

Irrespective of whether the respondent answered, ‘Yes’ or ‘No,’ 40% of feedback provided related to timing and access. Respondents that disagreed with the proposed change indicated that “30 days is more than enough time” (Individual, SM) and the proposed response times are too long. Others felt each investigation will be unique and each healthcare provider has access to different resources so it will be difficult to put a timescale on an investigation from the outset. Respondents also highlighted that including the timescales in regulations did raise concerns, which are outlined in the following comments; “We think policy is a better place to include timeframes rather than legislation as it means timeframes can be altered without going through the legislative process which can be lengthy” (General Medical Council) and “we would be concerned that including these changes in regulations, rather than in accompanying non-statutory guidance, may be over-burdensome and arbitrary, particularly in the primary care context” (British Medical Association Cymru Wales).

The majority of respondents agreed with the proposal and the narrative provide indicated that having “clear expectations of timeframes is very helpful but these need to be explained at the start of the process and throughout” (FTWW, Fair Treatment for the Women of Wales) and “clear and structured response times help ease stress for the individual” (Individual, JC).

Respondents acknowledged that there will be complexities in the investigations which mean it may take longer, and in these cases, it is suggested that “updates should be mandated so that the complainant is able to stay informed about the progress of the investigation” (Royal College of Nursing Wales).

Welsh Government response to Q11.

Welsh Government agrees that many concerns can be dealt with under early resolution and will not need to enter into the 30-day timeframe. It is clearly important that the NHS organisation discusses and shares with the complainant a realistic time frame for the investigation and response to a complaint raised. It is clear from the consultation responses that complaints are taking 6 months or longer to be answered. This was meant to be the exception and not the norm. Even where there is complexity, or more than one provider involved, the current number of complaints that are over the 30 working days and taking many months is unreasonable and the feedback from the consultation responses is clear in terms of the effect this is having on individuals and their families.

We do however recognise that patient safety incidents may take 2-3 months to reach the conclusion of the investigation and learning phases.

Welsh Government has benchmarked other nations timeframes for NHS complaints and find the 30 working days as a reasonable timeframe.

Welsh Government response to Q11 continued.

For complaints it seems appropriate that we remain with the 30-working day target but that the NHS organisation must set from the outset a realistic target date and stick to it. WG will also consider the best way of ensuring that during the course of the investigation complainants must be kept informed of any delay to that in addition to the existing regulations that require organisations to do this. There were significant responses during the consultation about the length of time investigations of complaints were taking and how many of them were exceeding the 30-day timeframe and many respondents explained that their complaint was not being answered in a timely manner or was taking in excess of 6 months or 1 year or longer to receive a reply. This is intended to be designed to enable extremely complex cases requiring external expert reports or consideration by different legal teams and not meant to apply to many cases. The suspension on the limitation period is also supposed to be implemented to protect the complainant’s ability to pursue a civil claims route if desired.

The consultation suggests this is not how it is for many complainants.

We will further discuss with stakeholders whether the reduction of the 12-month period for providing the investigation report to 6 months within the PTR regulations is a proportional step in response to these responses.

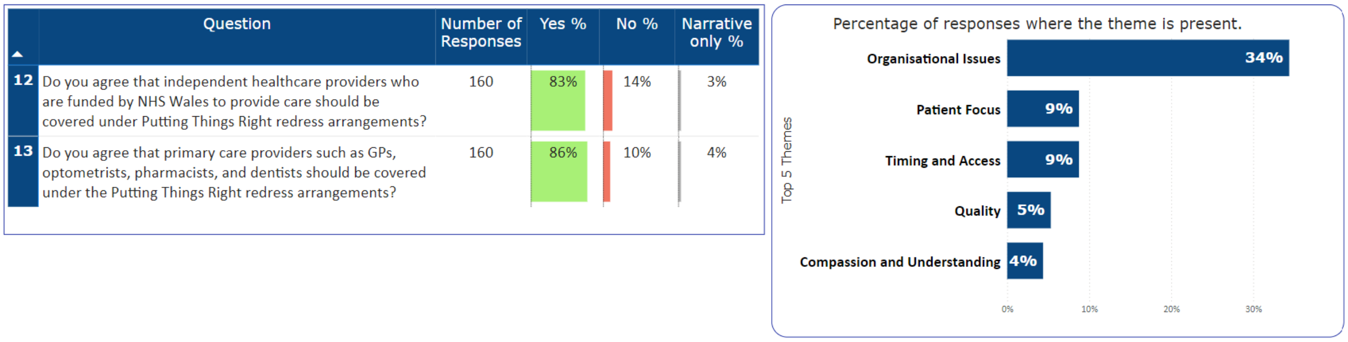
The substantial feedback pointed out that any further delay in the 30 working days targets for complaints would not be welcomed.

There is substantial reasoned opinion that for patient safety incidents they may require a proportionate investigation which can include multiple members of the MDT and this can take time to be completed well. Therefore, for patient safety incidents, organisations must state from the outset why the incident would require a 30, 60, 90 or 120 working day time frame and keep the person who has raised a concern regarding the patient safety incident updated.

Less serious concerns and feedback on the whole should be dealt with under the early resolution phase.

Welsh Government will also urge all organisations to develop a recovery action plan for their current complaints’ response position as part of the oversight arrangements between the NHS executive and NHS organisations.

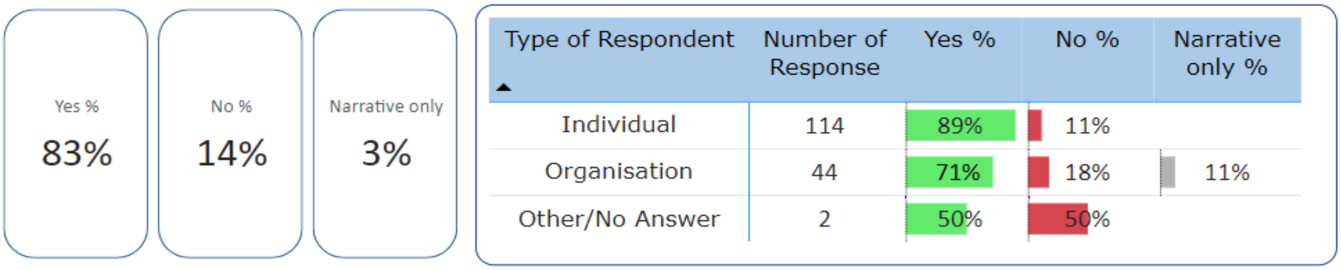
Reflecting changes in NHS Wales



	Question	Number of Responses	Yes %	No %	Narrative only %
12	Do you agree that independent healthcare providers who are funded by NHS Wales to provide care should be covered under Putting Things Right redress arrangements?	160	83%	14%	3%
13	Do you agree that primary care providers such as GPs, optometrists, pharmacists, and dentists should be covered under the Putting Things Right redress arrangements?	160	86%	10%	4%

Graphic 15: Theme and response summary of chapter 'Reflecting changes in NHS Wales'.

Question 12: Do you agree that independent healthcare providers who are funded by NHS Wales to provide care should be covered under Putting Things Right redress arrangements?



Yes %	No %	Narrative only
83%	14%	3%

Type of Respondent	Number of Response	Yes %	No %	Narrative only %
Individual	114	89%	11%	
Organisation	44	71%	18%	11%
Other/No Answer	2	50%	50%	

Graphic 16: Question 12 response and respondent overview.

Concerns raised about the proposal in this question included that current arrangements are not fit for purpose, so broadening the scope may be unwise. In addition to this, multiple respondents felt that by extending the redress arrangements this may cause further delays and compound any current issues. Some respondents highlighted that there may be financial and contractual issues with the implementation within independent healthcare; "not unless agreed contractually [it will have a] significant burden for some small contractors" another respondent raised a concern that "there would be a financial impact due to non-recoverable legal advice costs so the change would need to come with additional finance. [There were also discussions] around the reality of trying to implement this and how effective the system would be given the complex contracting arrangements in place with different providers" (Welsh Ambulance Service University NHS Trust).

Reflecting upon these statements, one answerer suggested "the complaints process and the liability of independent providers should be included as part of the contract arrangements when providers are commissioned" (Children's Commissioner for Wales).

Multiple comments questioned whether the term ‘independent health provider’ includes third sector organisations which may provide services funded by the NHS and one respondent asked, “who would train the independent sector on complaints/redress and how to manage an independent Putting Things Right (PTR) case out of the realm of the Health Board’s process?” (Swansea Bay University Health Board).

Although concerns were raised in response to this question, most respondents agreed with the proposal. Responses consistently highlighted guidance, process, and finances, which supported the consensus that processes should be consistent for all care funded by NHS Wales.

“A standard process for people whose care is funded by NHS Wales, whether that is through independent healthcare providers, or the NHS itself, would make things easier for people to understand and fairer across the healthcare system” (Learning Disability Wales) this statement is supported by multiple NHS Wales Health Board representative responses and reiterated in a response from the General Medical Council who felt that:

“This would guarantee that central guidance on handling concerns would exist in independent healthcare providers, and it would help ensure equality between patients treated in the NHS and those whose treatment was outsourced to an independent healthcare provider” (General Medical Council).

It is highlighted multiple times that service users may see independent healthcare providers as part of the NHS Wales as they are funded by them, so individuals should have the same rights as when they receive NHS delivered care. One respondent agreed with the proposal, however suggested “Clarity about roles and responsibilities in the Putting Things Right (PTR) process where services are commissioned or delivered in partnership would be helpful to ensure that patients and families have a smooth and coherent experience without unnecessary duplication of information or requests for feedback” (Marie Curie) this is underlined by the following statement “It would be very helpful to have one PTR process regardless of where the care is provided in relation to NHS services. It can be confusing for [the] complainant re different processes for independent contractors / social care providers and does not allow Health Boards to fully ascertain the quality of services provided that are funded by us. It does not support a joined-up response for complainants who do not understand the complexities of the current system” (Swansea Bay University Health Board).

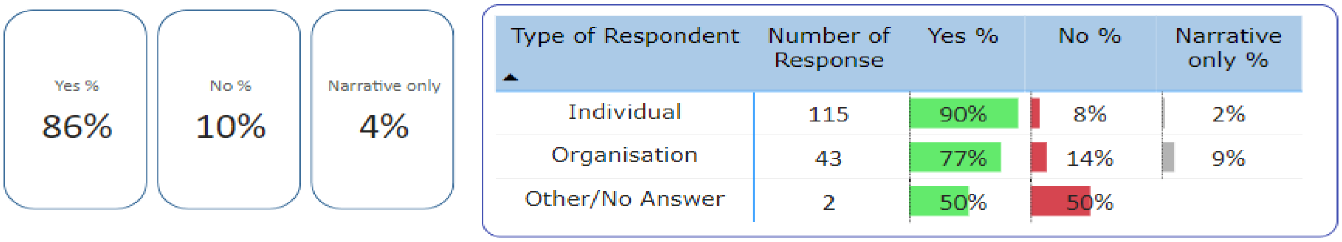
Welsh Government response to Q12.

Welsh Government recognises the challenges in the application of the NHS concerns, complaints, and redress arrangements regulations to NHS funded care in the independent sector. However, as a matter of principle we maintain that patients and their families should not be disadvantaged in terms of the availability of redress, including financial redress because the NHS organisation has chosen to commission the patient's care through an independent healthcare provider.

We will therefore work on the design of a protocol that would enable a joint discussion and agreement to be reached between the independent healthcare provider and the NHS organisation commissioning the care, to agree whether qualifying liability exists and whether redress settlement should be offered and what the extent of that offer consist of. We view that the arrangements for these may be best included in contracts with the independent healthcare sector by the NHS organisation which would reinforce clear responsibilities to enable the Welsh NHS body to fulfil their obligations under these regulations and any recuperation arrangements if required.

Qualifying Liability is understood to mean where someone breaches their duty of care to a patient, by failing to act according to the standards of a reasonably competent person, and this failure results in or causes the personal injury or loss)

Question 13: Do you agree that primary care providers such as GPs, optometrists, pharmacists, and dentists should be covered under the Putting Things Right redress arrangements?



Yes %	No %	Narrative only
86%	10%	4%

Type of Respondent	Number of Response	Yes %	No %	Narrative only %
Individual	115	90%	8%	2%
Organisation	43	77%	14%	9%
Other/No Answer	2	50%	50%	

Graphic 17: Question 13 response and respondent overview.

Respondents that disagreed with this proposal felt that primary care providers will already have their own processes and can deal with complaints on a more personal level whilst being more efficient. It was also questioned "how it would be possible to manage this huge number of additional possible complaints given that the current arrangements do not work to a satisfactory timescale. This will simply overload the process" (Individual, LR).

The topic of additional resources being required to deal with the increase in workload was raised by multiple respondents who agreed with the proposal, as outlined in the following statement: "How this would work with [the] current set up would need extensive thought. In

[Health Boards] HBs redress teams who are experienced deal with these cases. Primary care would not have the expertise to do this, however [Health Boards] HBs would need extra resources to be able to do it on their behalf. If [Health Boards] HBs, do it on behalf of primary care the whole concept of commenting on breach of duty and qualifying liability[7] would need to change" (Individual, JM).

Further concerns were also raised around redress and indemnity, which are outlined in the following comments: "Any expansion of the redress scheme to primary care must be funded centrally in a similar manner to how it is provided elsewhere in NHS Wales. If a GP practice were liable for a redress payment of up to £50,000 then this would represent a significant proportion of their turnover being diverted from the day-to-day costs of operating the practice. This in turn will have negative consequences on patient care and risk the sustainability of the practice" (British Medical Association Cymru Wales).

"In addition, unless NHS Wales also wishes to provide the indemnity cover for primary care providers then it is totally unreasonable to try to set standards for how a complaint will be handled as this could well be in conflict with the processes of the indemnity provider. There is a risk of pushing up indemnity costs for primary care providers as a result" (Community Pharmacy Wales).

Similarly to question 12, most respondents are in favour of the proposal and feedback in support of the change was also similar. The following statement summarises the sentiment well "Any service or organisation working with or funded by the NHS should be covered under the same complaints process - this not only ensures that services meet the same standards but also reduces confusion for those raising the complaints" (Individual, R).

Welsh Government response to Q13.

Welsh Government recognises and understands the concerns raised by organisations and individuals.

We will explore the feasibility of expanding the redress arrangement to include the GMPI fund and give careful thought to the feedback received on the challenges in applying redress arrangements to other primary care providers. If the decision is made to move forward with the GMPI fund's inclusion and thereby GP practices, then the intention would be that all costs of any redress settlement would be from the fund and not passed on to individual practices if a redress award were to be made.

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[7] Qualifying Liability is understood to mean where someone breaches their duty of care to a patient, by failing to act according to the standards of a reasonably competent person, and this failure results in or causes the personal injury or loss)

In addition to the previous questions within this chapter, we have also included a section (below) to include responses regarding social care…

Whilst analysing responses throughout the consultation it became clear that respondents felt that there needed to be more collaboration and alignment between the complaints and concerns procedures for health services and social services. Although this question was not raised as part of the consultation, due to the number of comments and concerns that were raised it was felt that this was pertinent to include at this point in the report. Individuals raised concerns about the communication between the services such as, “at present there is little or no liaison between health services and social services” (Anonymous respondent and Individual, TH).

However, more pertinently, others highlighted that there should be more collaboration between the services to ensure that the complaints and concerns processes are clear, easy to navigate and understand for the individual; “Where Social Services and Health Board staff work together side by side, e.g. in an integrated CMHT where both sides are bound by the 2010 Mental Health Measures (Wales), there should be one integrated complaints process. A mental health patient should not have to deal with the additional complexity and stress of making two complaints, with the scope of accountability being denied by both sides and getting "lost somewhere in the gap"” (Anonymous respondent).

This is a statement that is reiterated by one health organisation, which highlighted that having different processes for health and social care can cause confusion for complainants that are not aware of the complexities within and between the services. Finally on this point, Llais, reported that, “In our consultations with both staff and members of the public, a recurring theme has been the lack of alignment between the concerns and complaints process for health and the concerns and complaints process for social services. There needs to be greater connectivity between the two in the short term. In the longer term, we are calling on the Welsh Government to develop a single complaints pathway for people across health and social services” (LLais).

Welsh Government response to Q13B.

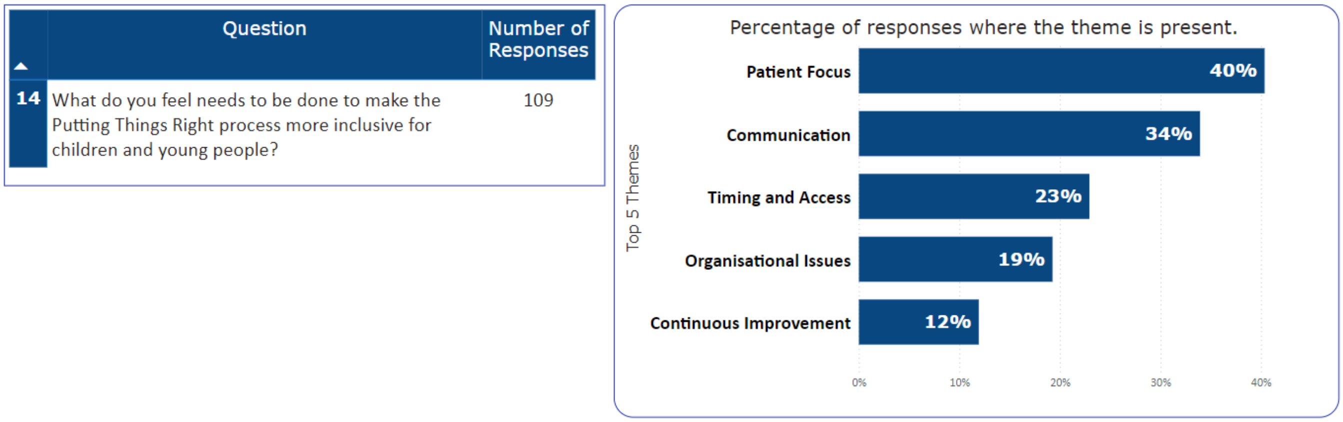
Welsh Government will consider whether there is sufficient flexibility within *Putting Things Right* and social services complaints processes to ensure that where there is integrated provision of care, and a complaint is made to both health and social services in connection with this, health boards and local authorities are able to hold a joint listening discussion, on early in the process. This will enable individuals to express their concerns to representatives from both health and social care; and from there, joint consideration to be given to which process would be most appropriate to handle aspects of their complaint. This should help to avoid the patient or client being redirected from one system to another.

We will also work to improve information and assistance available to people who wish to raise concerns about their care, to ensure they are able to navigate the system. The points made in response to this consultation will continue to inform our consideration of how complaints and concerns pathways across health and social services could be improved.

It is hoped any changes will reduce the need for a client or patient to make two separate complaints and would allow the health and social care representatives to ascertain which system is best to handle aspects of the complaint. This would then avoid the need for a client or patient being redirected repeatedly from one system to another.

Children and young people

Question 14: What do you feel needs to be done to make the Putting Things Right process more inclusive for children and young people?



	Question	Number of Responses
14	What do you feel needs to be done to make the Putting Things Right process more inclusive for children and young people?	109

Graphic 18: Theme and response summary of chapter ‘Children and young people’.

The topics of patient focus and patient support arose within 40% of comments provided in response to this question. With many respondents highlighting that the offer of advocacy is key, as outlined in the statement below and reiterated in much of the feedback provided.

"All children should have the opportunity to have advocacy in relation to their healthcare, should they want it. For children and young people who require advocacy but do not qualify for statutory provision already available, the option they are likely to be presented with currently is the Putting Things Right process, where children are advised to contact the MEIC [meicroffon - advocacy service] service. This is an important phone line / online service which demonstrates positive outcomes for children and young people, but it does not provide face-to-face advocacy support. That offer of independent, face-to-face (if requested) advocacy should be available to all children in Wales who are seeking to raise a concern or complaint" (Children Commissioner for Wales).

Another comment suggested that "engaging and consulting with children and young people groups across Wales - could provide feedback/ideas on how to make the PTR process more inclusive" (Hywel Dda University Health Board).

This suggestion is mirrored in other responses that felt that children's voices should be heard, and they should be treated equally throughout the process ensuring that they know their rights.

A third of the feedback provided to this question highlighted that effective communication will be key to making the process more inclusive for children and young people. Respondents suggested easy-read guidance aimed at children, using simple understandable language and others suggested the use of social media to raise awareness of the process amongst this demographic; "There are a number of things that could be done to make the Putting Things Right process more inclusive for children and young people; utilising social media to raise awareness of the process; engaging via schools, children's wards and youth groups; providing information in video and Easy Read format as standard; and specially trained advocates to support children and young people through the process were a number of suggestions made by those we have spoken to" (Llais).

Welsh Government response to Q14.

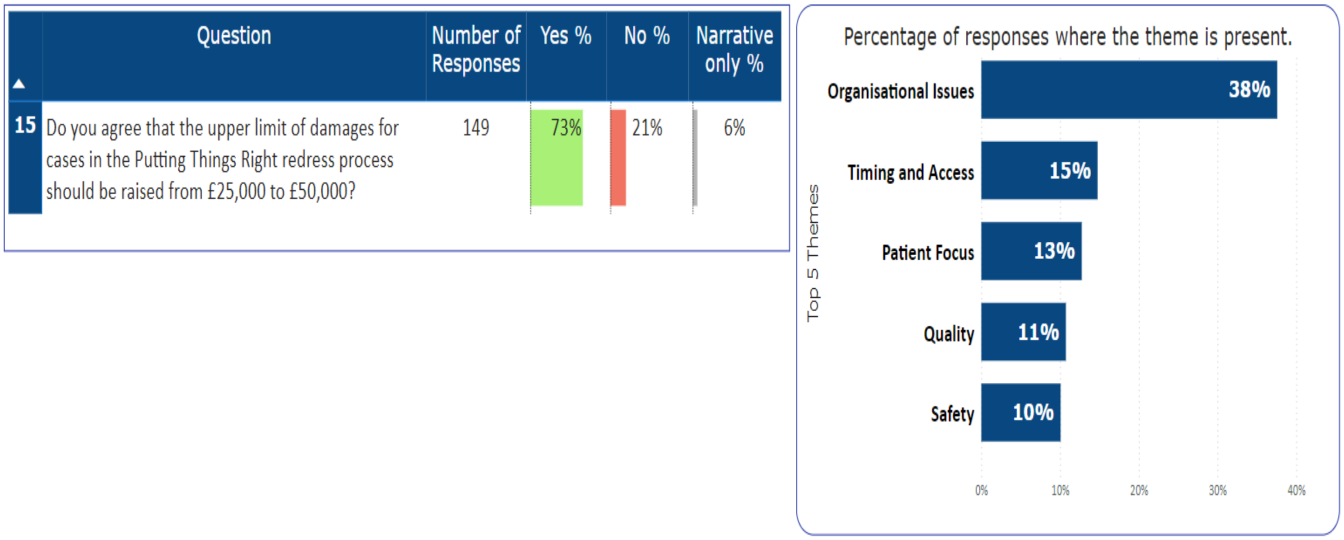
Welsh Government will undertake further work with key stakeholders to develop an approach through co-design to improve the access, pathway and system for children and young people to have their concerns about their health care heard and responded to.

Lessons from the feedback received and drawing from other successful systems will help develop and identify the improvements needed.

Welsh Government will consider how the stronger active offer of specialist advocacy for health complaints raised by children and young people will enable a greater focus on solution-based, problem-solving approaches.

Welsh Government will commission Children in Wales to undertake some co-design work with children and young people in Wales to design suitable solutions and supporting materials.

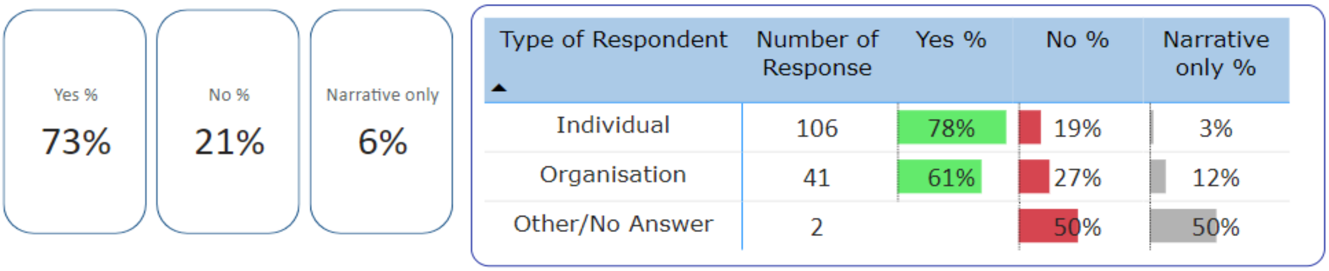
Redress in the form of financial compensation



	Question	Number of Responses	Yes %	No %	Narrative only %
15	Do you agree that the upper limit of damages for cases in the Putting Things Right redress process should be raised from £25,000 to £50,000?	149	73%	21%	6%

Graphic 19: Theme and response summary of chapter 'Redress in the form of financial compensation'.

Question 15: Do you agree that the upper limit of damages for cases in the Putting Things Right redress process should be raised from £25,000 to £50,000?



Yes %	No %	Narrative only
73%	21%	6%

Type of Respondent	Number of Response	Yes %	No %	Narrative only %
Individual	106	78%	19%	3%
Organisation	41	61%	27%	12%
Other/No Answer	2		50%	50%

Graphic 20: Question 15 response and respondent overview.

Due to the nature of this question, many of the responses relate back to finances but further comments are raised around organisational issues, including resources, guidance and processes and issues with the current scheme.

One sub-group of respondents that unanimously disagreed with the proposal outlined in this question was those that answered on behalf of a legal organisation. Of the 8 responses provided by this group, 100% of them disagreed that the upper limit should be increased. The group outlined multiple concerns with the proposal, a summary of their concerns has been outlined below:

- The current scheme does not work effectively and is not comprehensive enough to deal with cases worth up to £50,000, it was felt that the existing scheme would need to demonstrate it is effective and working as it was intended to, before the quantum limit is increased (Harding Evans and Action against Medical Accidents (AvMA)).

- It was felt that by increasing the upper limit of redress, it would be likely that a significant number of individuals would accept an offer of settlement below which they are entitled to, because there will be more scope for claims to be undervalued (Graystons Solicitors and Society of Clinical Injury Lawyers).

- Respondents felt that within the current system there does not appear to be an independent investigation, given that the first stage of the investigation is carried out by the health organisation and at no time is the individual involved in the investigation (Hugh James and Graystons Solicitors).

- It is highlighted that by increasing the upper limit, the more complex and sensitive the cases will likely be, which subsequently will require further expert reports and time to investigate. It is underlined that the fee structure proposed would be difficult to obtain, and the fees will not be attractive to lawyers which could lead to law firms not being willing to offer advice to clients within the remit of the Scheme (Thompsons Solicitors, Hugh James and Association of Personal Injury Lawyers (APIL)).
- Finally, respondents from this group underlined that other regulations and processes may need to be further considered in relation to the proposed changes, these have been outlined below:

  - “We would question whether raising the limit to £50,000 is now, in any event, required since there is now a fixed recoverable cost arrangement available under the Civil Procedure Rules for more straightforward clinical negligence cases up to £100,000” (Hugh James).

  - “This proposal would be out of kilter with other reforms and schemes in personal injury, such as the proposed scheme fixed recoverable costs in lower damages clinical negligence claims proposed for England and Wales” (Graystons Solicitors).

    “There is already an element of discretion under Part 6, section 29 of the regulations, which allows the NHS body to consider an award exceeding £25,000 if the investigation conducted concludes that there is a qualifying liability[8] ... APIL believes that the discretion element in the regulations can address the concerns in the consultation that cases are removed out of the redress scheme due to changes in damages since 2011” (Association of Personal Injury Lawyers (APIL).

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[8] Qualifying Liability is understood to mean where someone breaches their duty of care to a patient, by failing to act according to the standards of a reasonably competent person, and this failure results in or causes the personal injury or loss)

Welsh Government response to legal association responses.

Welsh Government is grateful for the response from the legal community with relation to this proposal. We recognise the respondents' expertise and for that reason has undertaken sub-group analysis to consider these separately from the general responses received by citizens to better understand them.

In the development of the consideration of this proposal Welsh Government undertook several pieces of analysis prior to the consultation. Three years' of real *Putting Things Right* complaints, Redress claims settled, and clinical negligence claims were analysed. Additionally, Welsh Government compared in detail the Judicial College guidelines on damages published in 2009 with the same guidance published in 2023. Each line of damages was then compared with its comparator in 2023 to assess if there had been any change in the recommended damages for each individual condition. There was a mean of 44.53% to 47.58% increase in the damages, which when applied to the original £25,000 limit equated to just under £40,000. The analysis of the claims data also suggested some injuries were now falling outside of the redress system which may have been included previously.

The figure of £50,000 was an attempt to provide some inflationary future proofing to the Redress system.

Welsh Government officials and Legal and Risk services have been working with Department for Health and Social Care colleagues in understanding the Fixed Recoverable Costs (FRC) for low-value clinical negligence claims and how it may relate to Wales. We understand that the intention has been that when this does commence the intention is to start this at a £25,000 limit but also recognise that clinical negligence claims may enter the intermediate pathway with a limit of £100,000. It should be recognised that the FRC is predicated on the claimant accessing legal representation and through setting the costs claimant solicitors can be reimbursed.

The *Putting Things Right* system puts the onus on the NHS body to undertake a proportionate investigation, share all relevant records and the investigation report and admit liability (where it is found to exist) and supports the reimbursement of legal fees to enable citizens in Wales access to skilled clinical negligence legal expertise and advocacy.

The criticism that the *Putting Things Right* system does not currently work effectively and is not comprehensive enough is the very reason the reform of the system is needed, and this

…….it would be likely that a significant number of individuals would accept an offer of settlement below which they are entitled to, ……more scope for claims to be undervalued

Welsh Government recognises this concern within the respondent's feedback. The importance given to the active offer of funded independent legal advice is key to mitigating this risk to help complainants understand the value of the redress offer being made. The NHS body makes this offer based upon the NHS specialist legal advice and the Judicial College guidelines on damages.

……. there does not appear to be an independent investigation, and at no time is the individual involved in the investigation….

These are recognised and valid points. Welsh Government will be considering how to ensure that the individual is better included in the development of the scope of the investigation for serious harm complaints and incidents. The use of the medical examiner service and external medical experts in the most serious cases will also be reviewed although the length of time this can add to a complaint investigation is significant.

The Public Service Ombudsman for Wales was among the other respondents who also suggested a review of the independence of the investigation must be considered when death has occurred. Welsh Government will consider how best to provide a level of safeguard in this regard.

……. the more complex and sensitive the cases will likely be, which subsequently will require further expert reports and time to investigate.

The current regulations afford NHS bodies the ability to consider whether an offer of redress should be made. This is a balance not only on whether qualifying liability exists but also whether the threshold for damages is under the £25,000 limit or it the case is appropriate for consideration under redress. Welsh Government intends to develop greater clarity in the statutory guidance that where a case is deemed complex, sensitive or specialist such as some court of protection cases the case should, after taking legal advice, be subject to civil proceedings.

Qualifying Liability is understood to mean where someone breaches their duty of care to a patient, by failing to act according to the standards of a reasonably competent person, and this failure results in or causes the personal injury or loss)

… that the fee structure proposed would be difficult to obtain, and the fees will not be attractive to lawyers which could lead to law firms not being willing to offer advice to clients within the remit of the Scheme…

Welsh Government recognises this risk and steadfastly aims to avoid the undesirable reduction of access to justice for patients and their families by providing adequate mitigation to these concerns.

Welsh Government will explore further the possibility of matching the fixed fees in the FRC scheme for low value clinical negligence claims to avoid any disparity or disincentive as the FRC will, when it comes in to force, be mandatory for all civil claims that do not go through the redress system in Wales. The level of fixed fees has already been the subject of two extensive public consultation exercises undertaken by UK government as well as significant stakeholder engagement. Welsh Government will consider the feasibility of ensuring that where figures rise over time in England and Wales for the FRC fixed fees.

There were also concerns raised about the current capacity available to deal with redress cases. It was felt that if the upper limit is increased then the number of cases will also increase, this will mean that staffing levels would need to be adequate to provide capacity for this change. This is a concern highlighted in responses that agreed with the proposal as well. This shared concern is summarised in the following statement, “This increase could potentially double the workload for existing teams and so consideration will be needed to suitable additional resourcing and finance to maintain quality of this work stream” (Welsh NHS Confederation).

Although concerns have been raised, a clear majority of respondents agreed with the proposal and in contrast to the previous points, many respondents felt this will benefit individuals by enabling them to receive early redress and reduce the need for legal action. Ultimately, reducing stress for the complainant, as underlined in the following statement, “A revised upper limit of damages would be quicker and better for patients and a less costly legal process for Health Boards” (Swansea Bay University Health Board).

It is also highlighted many times by respondents that they did not make a complaint for financial redress, but to ensure accountability and make sure that systems are fit for purpose. As highlighted in the following statements:

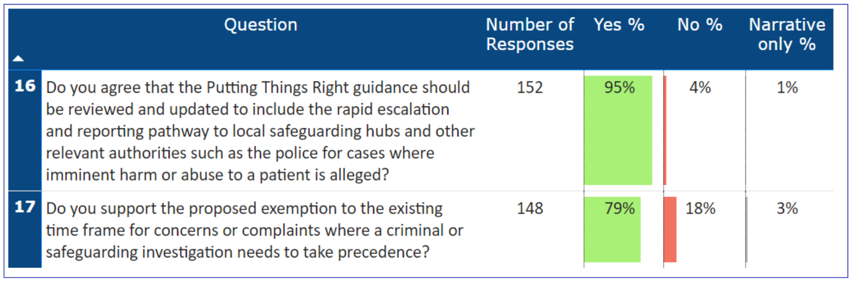
“For me it’s not about a financial gain, it is about getting the right treatment and putting it right when you have had to fight for something that I believe should have been done and wasn’t in the beginning which had then led to years of additional suffering” (Individual, SJ).

“Many people told us they just wanted to be heard, and they did not want what they experienced to happen to someone else. Avoiding the lengthy and expensive litigation process as much as possible is a sensible approach to achieving this outcome” (Age Connect Morgannwg).

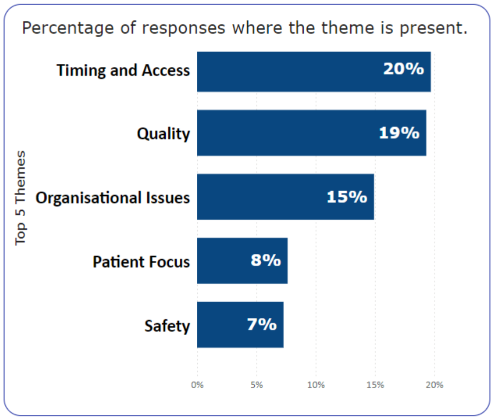
Welsh Government response to Q15.

While the individual and many organisational responses were broadly in agreement and supportive of the proposal, careful consideration to the consequences of bringing this in will be considered especially in conjunction with the concerns from the legal community. Representation from Llais also raised points that complainants may not want to be seen as being focused on redress payments however may need to be made aware when they are entitled to them. We will now develop this proposal in line with the published intention but will include the cautions that have been raised.

Urgent concerns and deliberate harm

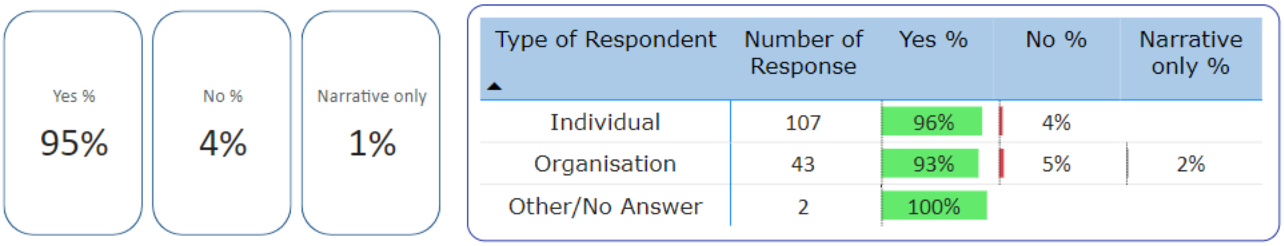


	Question	Number of Responses	Yes %	No %	Narrative only %
16	Do you agree that the Putting Things Right guidance should be reviewed and updated to include the rapid escalation and reporting pathway to local safeguarding hubs and other relevant authorities such as the police for cases where imminent harm or abuse to a patient is alleged?	152	95%	4%	1%
17	Do you support the proposed exemption to the existing time frame for concerns or complaints where a criminal or safeguarding investigation needs to take precedence?	148	79%	18%	3%



Graphic 21: Theme and response summary of chapter ‘Urgent concerns and deliberate harm’.

Question 16: Do you agree that the Putting Things Right guidance should be reviewed and updated to include the rapid escalation and reporting pathway to local safeguarding hubs and other relevant authorities such as the police for cases where imminent harm or abuse to a patient is alleged?



Yes %	No %	Narrative only
95%	4%	1%

Type of Respondent	Number of Response	Yes %	No %	Narrative only %
Individual	107	96%	4%	
Organisation	43	93%	5%	2%
Other/No Answer	2	100%		

Graphic 22: Question 16 response and respondent overview.

Only a small number of respondents disagreed with this proposal, however, one respondent suggested; “The Putting Things Right guidance should make clear, when any abuse to a patient is alleged, that the case should be rapidly reported to local safeguarding hubs and other relevant authorities. RCN Wales is currently unclear as to what is meant by “imminent harm” in this question and would like to know how a definition of “imminent harm” would relate to clinical risk” (Royal College of Nursing Wales).

Many respondents that were in agreement with the proposal highlighted that this is key to ensure the care and safety of individuals.

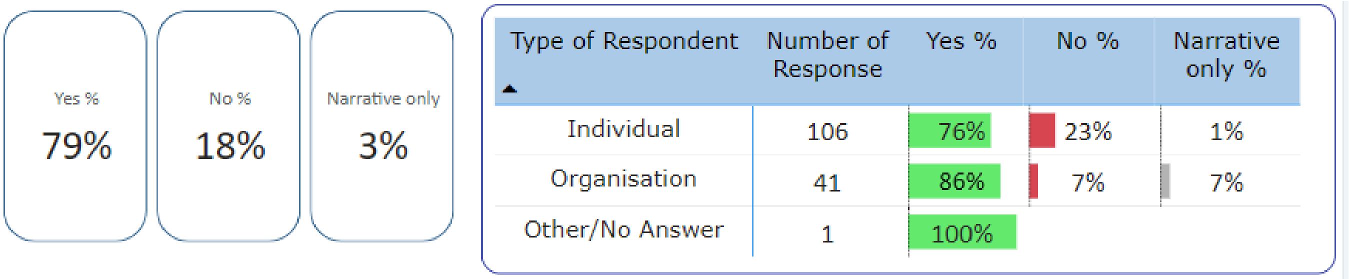
“Safeguarding issues should always override the complaints process and be dealt with in the first instance” (Individual, AE).

“Including information in guidance on [the] relevant pathways for rapid escalation in cases where imminent harm or abuse to a patient is appropriate” (British Medical Association, Cymru Wales).

Welsh Government response to Q16.

We will consider the most effective way of addressing this in the guidance so that the actions are clear to organisations and individuals and support the All-Wales Safeguarding procedures as outlined in Social Services and Wellbeing (Wales) Act 2014 and statutory safeguarding guidance Working Together to Safeguard People.

Question 17: Do you support the proposed exemption to the existing time frame for concerns or complaints where a criminal or safeguarding investigation needs to take precedence?



Yes %	No %	Narrative only
79%	18%	3%

Type of Respondent	Number of Response	Yes %	No %	Narrative only %
Individual	106	76%	23%	1%
Organisation	41	86%	7%	7%
Other/No Answer	1	100%		

Graphic 23: Question 17 response and respondent overview.

Those respondents that disagreed with the proposal, cited that time and access would be an issue. Feedback indicated concerns that the proposal would delay outcomes and that timeframes should be adhered to. One response acknowledged that there would need to be exemptions to existing timeframes, however stated; “We would argue there needs to be better evidence for justifying the exemption to the existing time frame for concerns or complaints where a criminal or safeguarding investigation is taking place. Would an NHS response necessarily interfere with the criminal investigation? Would the outcome of a criminal investigation influence the NHS response to a patient’s complaint? The concern would be if a criminal investigation takes a prolonged period and therefore precludes the award of compensation until that investigation is complete” (Learning Disability Wales).

Another respondent highlighted “It is accepted that concerns of this nature that involve external third parties are of importance, but not that there should be an automatic exemption for these cases where it is still possible that the Health Board can address the concern raised to them without compromising the investigation. It should be decided on a case-by-case basis” (Thompsons Solicitors).

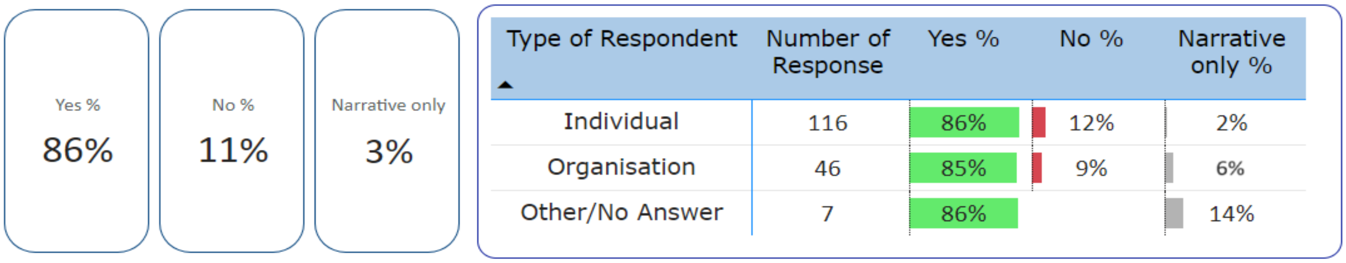
Although there were some concerns raised in response to this question, the majority agreed with the proposal and many respondents highlighted that any criminal or safeguarding investigation needs to take precedence. One respondent felt “There needs to be clear guidance on communication and regular contact with the complaint during this period, for them to understand the delay and feel supported during this time” (Individual, SD) which is a point that is reiterated by other respondents and throughout the consultation. Furthermore, it is suggested that “If there are other concerns about the same individual but that don't form the basis of the third-party investigation, these matters should still be progressed if possible” (General Medical Council).

Welsh Government response to Q17.

We will progress with including the exemption to the time frame for the purposes of a criminal or safeguarding investigation where it takes precedence and where the lead investigator indicates the NHS’ investigation may interfere with that inquiry. It should be started or resumed at the earliest opportunity. Where it is still possible the NHS organisation can address the concerns raised without compromising the investigation, for example through early resolution or a delayed start investigation it should be undertaken where all agree the conflict is no longer present.

Bereavement

Question 18: In the event of a patient’s death and where their loved ones had concerns about their care, do you agree that the NHS body should use the listening meeting offered in the early resolution phase (stage one) in order to try and resolve the bereaved person’s concerns quickly?



Yes %	No %	Narrative only
86%	11%	3%

Type of Respondent	Number of Response	Yes %	No %	Narrative only %
Individual	116	86%	12%	2%
Organisation	46	85%	9%	6%
Other/No Answer	7	86%		14%

Graphic 24: Question 18 response and respondent overview.

Respondents that disagreed with the proposal underlined concerns around timing and access within 35% of their comments. Respondents felt that the families will need time to properly consider and process what has happened and should not feel rushed.

One respondent highlighted that this will “depend on how long the new early resolution phase ends up being. Families are dealing with enough in the first two weeks of loss, this offer should not add more pressure to them. It is a good thing as long as they can access in their own time” (Individual, Name not provided).

Others highlighted that this would need to be considered on a case-by-case basis and the full context of the situation will need to be examined because all families will feel differently during their time of bereavement.

Respondents also indicated that there will be a need to remain person focused to ensure that families attain the best possible outcome, “The family should not feel under pressure to accept a resolution at that point unless they expressly seek it. Situations could easily arise where an unfair resolution is reached” (Harding Evans).

A large majority agreed that the NHS body should use the listening meeting offered in the early resolution phase (stage one) in order to try and resolve the bereaved person’s concerns quickly.

From the narrative that respondents provided in agreement, it was felt that effective communication was key for this to work. One respondent highlighted “a listening meeting discussing bereavement needs to have more substance to it than a simple ‘sorry.’ It needs to be sensitively and professionally handled to avoid bias in favour of the NHS body and be comprehensive enough to provide people with answers” (FTWW, Fair Treatment for the Women of Wales).

Multiple comments stated that early opportunities to listen to bereaved families will be key and that any lack of communication at this point may have a detrimental effect on relationships and further communication.

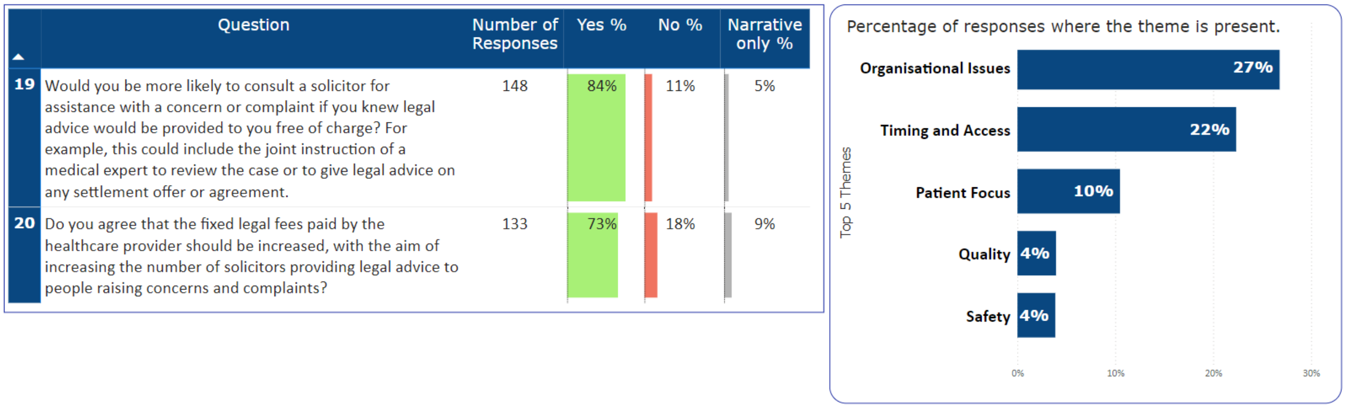
It was also suggested that meeting at the early resolution stage would be the most patient-centred approach. With multiple respondents highlighting that this meeting will provide families with the chance to ask questions about any concerns. Many respondents also encouraged the need to offer further support to the bereaved family at this meeting; “In cases where loved ones have concerns about the events leading up to a patient’s death, we are generally supportive of the proposal to use the listening meeting offered in the early resolution phase to try and resolve the bereaved person’s concerns quickly. However, it is important to recognise that a bereaved person may be in a vulnerable state at this time, and an offer of or at least signposting towards bereavement support should be made available to them” (Marie Curie).

The importance of compassion and understanding is raised consistently in feedback and due to the sensitivities and difficulties that families will be experiencing, it is underlined by multiple respondents that it is important that the staff facilitating the meetings are trained to deal with these difficult and sensitive conversations.

Welsh Government response to Q18.

We will work with key stakeholders to design the approach to be undertaken to improve the care of those who are bereaved and who have questions and concerns about the care provided to their loved one. We will also ensure this is linked to the National Bereavement Strategy and include this in the training and education for the NHS.

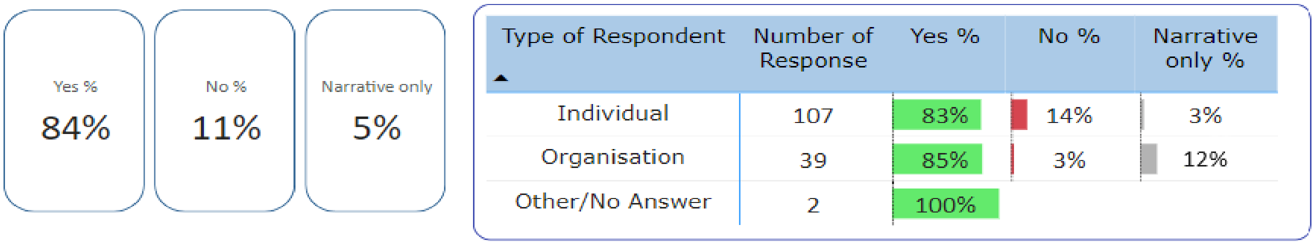
Provision of free legal advice



	Question	Number of Responses	Yes %	No %	Narrative only %
19	Would you be more likely to consult a solicitor for assistance with a concern or complaint if you knew legal advice would be provided to you free of charge? For example, this could include the joint instruction of a medical expert to review the case or to give legal advice on any settlement offer or agreement.	148	84%	11%	5%
20	Do you agree that the fixed legal fees paid by the healthcare provider should be increased, with the aim of increasing the number of solicitors providing legal advice to people raising concerns and complaints?	133	73%	18%	9%

Graphic 25: Theme and response summary of chapter ‘Provision of free legal advice’.

Question 19: Would you be more likely to consult a solicitor for assistance with a concern or complaint if you knew legal advice would be provided to you free of charge? For example, this could include the joint instruction of a medical expert to review the case or to give legal advice on any settlement offer or agreement.



Yes %
84%

No %
11%

Narrative only
5%

Type of Respondent	Number of Response	Yes %	No %	Narrative only %
Individual	107	83%	14%	3%
Organisation	39	85%	3%	12%
Other/No Answer	2	100%		

Graphic 26: Question 19 response and respondent overview.

There is a contrast in response to this question based on the respondent type which is highlighted in graphic 26 (above).

40% of the comments in disagreement with the proposal highlighted finances as a reason. With some unconvinced that providing legal advice free of charge is valid use of NHS funding, and others highlighting that this may promote ‘no win no fee.’ Others highlighted that they did not make a complaint for compensation, they “just needed to be sure that it couldn’t happen to us or others again” (Individual, JLG).

Another common feeling underlined by respondents to this question was of distrust for the NHS to provide impartial advice, which is underlined in the following comments:

“I would want independent advice and would not get this from the NHS. No trust” (Anonymous respondent) and “Couldn’t trust any expert that is jointly instructed” (Individual, HW).

It is also felt that there is a “a lack of independence within the process: The NHS body is responsible for determining whether there is a qualifying liability[9] and if the issue is serious enough to be allowed into the Redress Scheme. There is a lack of impartiality and objectivity in the process, and this is reported to be one of the biggest barriers to cases entering the scheme. The Welsh government needs to suggest proposals that introduce an element of independence to this process” (Action against Medical Accidents (AvMA)).

One respondent that agreed with the proposal suggested that legal advice should be independently organised by a third sector organisation or Llais.

There was a consensus within the group that agreed with the proposal that access to free legal advice needs to be promoted widely so that complainants are aware of the offer. As highlighted in the following statement, individuals may not know this is available; “In conjunction with this question, we also asked our respondents if they knew free legal advice was available to them – 85% said they did not know that free legal advice was available or how to access it, with only 15% saying they did know” (Fair Treatment for the Women Wales, FTWW).

Furthermore, many respondents felt that this needs to be made clear and transparent at the outset of the process, with one respondent suggesting; it “should be promoted widely both

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[9] Qualifying Liability is understood to mean where someone breaches their duty of care to a patient, by failing to act according to the standards of a reasonably competent person, and this failure results in or causes the personal injury or loss)

online and offline for those who are digitally excluded, to ensure that all complaints know that it is available" (Age Cymru).

While most respondents agreed with the proposal, there were some concerns raised within that group. It was underlined by some respondents that the proposal might promote vexatious complaints so there will need to be clear guidelines on vexatious claims and the consequences for these.

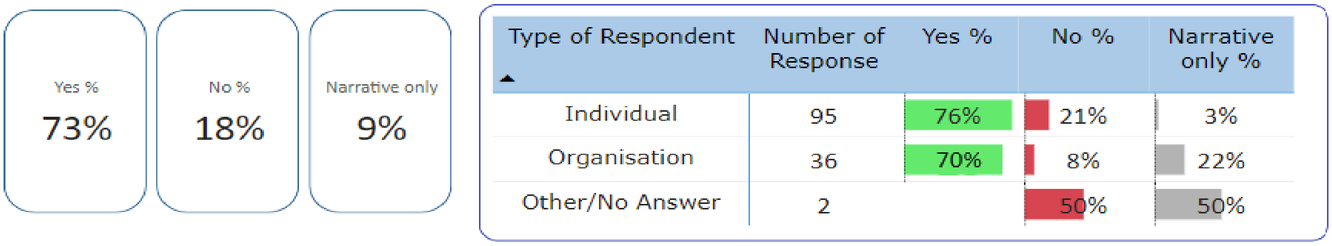
Others highlighted that with the proposed increase outlined in question 15 the proposal may cause capacity issues for legal representatives, meaning there may be a lack of legal support available for individuals.

Welsh Government response to Q19.

We recognise the concerns raised and will consider the points around building independence into the system. Part of the issue, as raised in feedback, is that there appears to be some misunderstanding of, or lack of clarity around, the meaning of the regulations and guidance. The regulations currently place a responsibility on the NHS body, where it has determined that a qualifying liability exists or may exist, to ensure that legal advice without charge is available in relation to the instruction of joint medical experts, any offer of redress, any refusal to make an offer of redress, or any settlement that is proposed. The proposal is to clarify the responsibilities of the organisations and that they should inform complainants of the availability of this advice, and to ensure that the guidance and information available makes it clearer that complainants can then choose representatives who have the specified expertise in clinical negligence. We propose to review the regulations and guidance to achieve this improved clarity where possible and achievable.

Qualifying Liability is understood to mean where someone breaches their duty of care to a patient, by failing to act according to the standards of a reasonably competent person, and this failure results in or causes the personal injury or loss)

Question 20: Do you agree that the fixed legal fees paid by the healthcare provider should be increased, with the aim of increasing the number of solicitors providing legal advice to people raising concerns and complaints?



Yes %
73%

No %
18%

Narrative only
9%

Type of Respondent ▲	Number of Response	Yes %	No %	Narrative only %
Individual	95	76%	21%	3%
Organisation	36	70%	8%	22%
Other/No Answer	2		50%	50%

Graphic 27: Question 20 response and respondent overview.

Once again, there is a contrast in response to this question based on the respondent type which is highlighted in graphic 27 above.

Of the respondents that disagreed with the proposal, many felt that money should be used to prevent complaints being made in the first place and to improve the service. It was also highlighted by respondents that this may not be appropriate for primary and independent care providers, for example:

“This is not appropriate for community pharmacies who operate private indemnity arrangements often with companies not located in Wales” (Community Pharmacy Wales).

“BMA Cymru Wales understands the rationale set out for these changes, and broadly agrees with the objective. However, as set out above, if GPs are to be included in the redress process, then we would seek further clarity as to where responsibility would lie for funding payments for legal advice” (British Medical Association Cymru Wales).

24% of comments cited finances, and many acknowledged that legal advice can be costly and this needs to be reflected in the fixed legal fees paid by the healthcare provider to be in line with inflation. Respondents felt that by implementing this increase it may encourage more solicitors to consider the complaints and redress processes before instigating the claims process. One respondent suggested there should be a “maximum amount [the] NHS can pay in fees … because it’s a massive waste of money” (Individual, JLG).

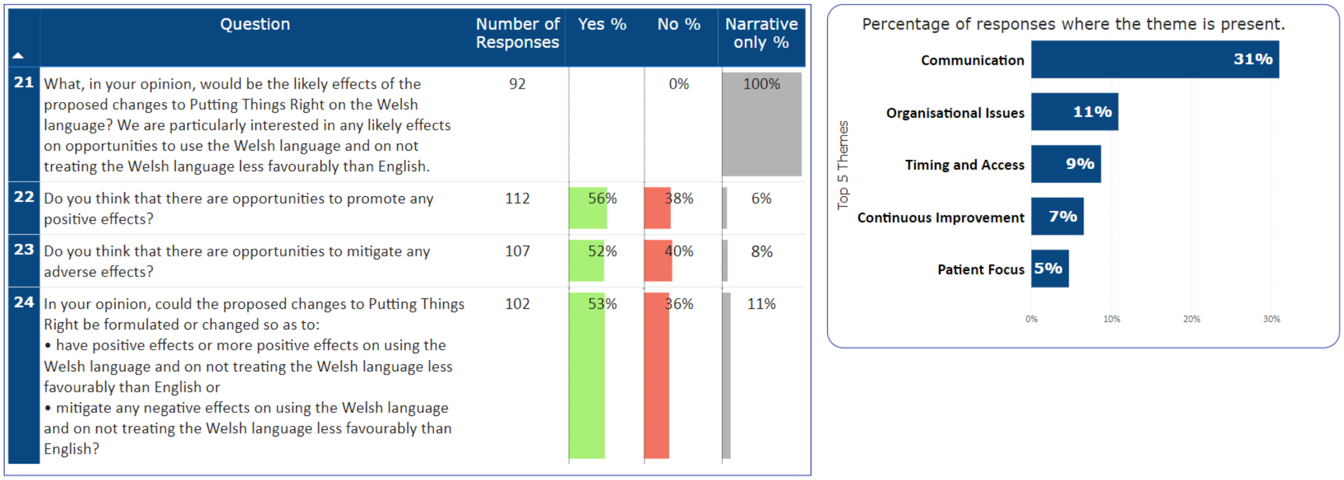
There are multiple responses that agree with the proposal but feel that the fees need to realistically “reflect the time spent on advising and assisting the client with the cases” (Thompsons Solicitors) and others felt that suggested fee increases may not be enough. One suggestion to ensure that these changes have the desired effect came in the following statement: “To involve the likes of ourselves in discussions, could produce a more open and workable system for all concerned. To decide without involving the right people will cause there to be less who will be able assist and that will create problems for the vulnerable in society and will cause a direct Access to Justice issue” (Grayston Solicitors).

Welsh Government response to Q20.

Welsh Government recognises the concerns of the legal clinical negligence community with regards to these proposals. We also accept that for some more complicated cases that additional costs may be required, such as cases under Part 7 of the Putting Things Right Regulations. We proposes matching the fixed rate amounts in the England and Wales FRC scheme for low value clinical negligence claims which have already been part of two public wide consultation exercises. It is recognised the *Putting Things Right* process should mean that decision on qualifying liability admission by the Welsh NHS body should have been made and a proportionate investigation completed and shared with the complainant and their legal representative. Although this does not in any way minimise the work needed in these claims it is felt to reduce some of work required.

Qualifying Liability is understood to mean where someone breaches their duty of care to a patient, by failing to act according to the standards of a reasonably competent person, and this failure results in or causes the personal injury or loss)

Welsh Language



	Question	Number of Responses	Yes %	No %	Narrative only %
21	What, in your opinion, would be the likely effects of the proposed changes to Putting Things Right on the Welsh language? We are particularly interested in any likely effects on opportunities to use the Welsh language and on not treating the Welsh language less favourably than English.	92		0%	100%
22	Do you think that there are opportunities to promote any positive effects?	112	56%	38%	6%
23	Do you think that there are opportunities to mitigate any adverse effects?	107	52%	40%	8%
24	In your opinion, could the proposed changes to Putting Things Right be formulated or changed so as to: • have positive effects or more positive effects on using the Welsh language and on not treating the Welsh language less favourably than English or • mitigate any negative effects on using the Welsh language and on not treating the Welsh language less favourably than English?	102	53%	36%	11%

Graphic 26: Theme and response summary of chapter 'Welsh language.

This chapter was comprised of four questions, which aimed to attain the respondents' views on how the proposed changes to Putting Things Right would or could affect the Welsh language. The number of responses received for the four questions ranged from 89 to 110 and there was some disparity in the 'yes/no' responses for question 22, 23 and 24. Many respondents highlighted that complainants should have the option to communicate in the language of their choice. It is highlighted by more than one respondent that the proposed changes to the Putting Things Right process will promote an emphasis on communication throughout, so the availability for individuals to communicate in Welsh will need to be reflected in the changes.

"The proposed changes to the PTR process would lead to an improvement, and therefore increase, in communication and correspondence with patients/complainants; while RCN Wales would welcome this, it is crucial that this is done in a way that allows the patient/complainant to both engage with, and receive all communication and correspondence relating to, the complaints process fully in Welsh if they wish" (Royal College of Nursing Wales).

Others underlined that it will be important for respondents to be able to communicate in their first language to ensure better understanding of the process. The importance of understanding and transparency throughout the process is something that has been raised multiple times in response to previous questions.

Concerns were raised in response to this chapter about staffing and resources, and it is highlighted multiple times that teams will need to ensure that they have enough Welsh speaking staff to facilitate the proposed listening meetings during the process. It is also underlined that there may be issues with specialist staff not being able to communicate in Welsh, subsequently requiring the need for translators, "It will be important to consider how NHS bodies will plan for having Welsh speaking (and other community languages) staff with sufficient subject specific expertise or interpreters to attend meetings within a short time limit." (Llais) and another respondent highlighted; "However, all parties in attendance at meetings may have varying level of understanding and speaking in Welsh and may need support from interpreters/language line" (Hywel Dda University Health Board).

Following on from this, the timing and access theme arises in feedback, with some respondents feeling that if the complainants first language is Welsh then the process should not be delayed in any way because of this. However, others felt that due to the lack of resources available in some areas, additional time may need to be factored in.

Whilst there is some disparity in the 'yes/no' responses to the final three questions of the chapter, many respondents that answered 'no' highlighted that "if the Welsh language is treated similarly to the English, then there should not be an issue" (Anonymous respondent) and "We do not believe there would be a differential impact based on language" (The Royal College of Surgeons of Edinburgh).

Moving forward, one respondent suggested, that by "Ensuring there is a systematic process for reviewing the impacts of proposed changes on the Welsh language and adapting them as necessary in response to feedback from stakeholders like Llais. This iterative approach allows for continuous improvement in the Putting Things Right Process regarding the Welsh language" (Llais).

Welsh Government response to Welsh language questions.

We feel the improved active offer of patient centred listening, consideration of accessibility and language needs and a proactive offer of advocacy which would include Welsh speakers is a step forward to ensuring that the Welsh language standards are supported.

The feedback provided with regards to the questions 21, 22, 23 and 24 and the degree of duplication or cross over subject matter has been feedback to the Welsh language policy team for consideration.

Additional Comments

Question 25: We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them.

In total 68 responses were received for question 25 of the consultation. Once again, we would like to thank those respondents who shared their personal stories and reiterate that the experiences shared in response to this question provide an extremely helpful insight and have been carefully considered on an individual basis.

Responses to this question addressed a range of subjects and respondents adopted a variety of approaches when providing their feedback. Whilst some revisited and added to their personal stories introduced in question 1, others pointed out aspects that they felt were overlooked during the consultation process. Additionally, some respondents summarised the answers they provided throughout their feedback to each question.

Despite the variety in responses, much of the narrative aligns with the themes used throughout our analysis. Therefore, like the reporting of question 1 responses, we have selected extracts from the 67 responses to this question and categorised them by theme. We recognise that this does not include all responses but believe it provides an insight into the feelings, suggestions and feedback expressed in response to this question.

Communication

- “Any changes for the better in communications with people who feel the need to communicate a concern or complaint is a good thing. I strongly believe patient liaison and child-related professionals should be better involved in the process, for all parties.” (Individual, asked to remain anonymous).

- “Welsh Government officials are encouraged to produce child/young people friendly versions of all guidance, consultations and policy documents where they have determined that policy proposals/legislation will affect children and young people. Communication should be appropriate for children and young people and relevant to their age, understanding and speech, language and communication needs.

I am therefore disappointed that no Children's Rights Impact Assessment has been published alongside this consultation, particularly considering the specific focus on children in some of these proposals." (Children's Commissioner for Wales).

Compassion and Understanding

- "The tone and approach to communications around concerns and complaints needs to be revisited, so that patient experience and wellbeing is foremost. This will need a significant culture shift away from the existing, more 'defensive' style of communication, where the sense is that health boards' commitment is to their reputation over and above the patient and their loved ones." (Fair Treatment for the Women of Wales).

- "The insincere and disingenuous response and attitudes should be addressed; we are here to serve our [patients] and their families." (Anonymous respondent).

Patient Focus

- "A person's experience [should be] seen in its entirety, rather than as multiple separate complaints with no overarching outcome." (Older People's Commissioner).

- "In terms of accessibility, hard to reach communities and barriers to raising concerns should be reflected in the process. Also, ensuring there is clarity of what should be expected of the people raising the concern would be helpful, for example behaviour, use of social media, vexatious complainants etc. In terms of support for staff, a consistent structure for this would be beneficial." (The Welsh NHS Confederation).

- "There is no mention in the consultation of how the PTR process will be culturally inclusive or accessible to people with sensory impairments, neurodiversity, or additional learning needs (for example, through the adoption of 'Ask Listen Do' principles)." (Marie Curie).

Quality

- "I don't know what a resolution looks like," to paraphrase the Health Board investigating officer in their complaint response to me, [this] is not a resolution. Meaningful resolutions need to be agreed. It is supposed to be "Putting Things Right." (Anonymous respondent).

- "However, everyone I contacted did not try to help. The medical professionals gave the wrong information to the coroner's office and so his death certificate was incorrect and still is." (Individual, MCS)

Safety

- "In relation to birth injuries and the effects it has on you later [down the line], [and how it] is not enough to raise this as a complaint. I'm only now feeling like I semi understand some of what went wrong, [and] it's affected by ability to go on and have more children which I would have always done. My daughters still under investigations to find out exactly what trauma she faced and why she struggles so much.” (Individual, PH).

- “I am particularly concerned on the level of training that practitioners are now receiving before they give care. It should always be made clear to patients and their carers who they are dealing with. We should not only say, "Hello my name is...." but also "and i am a ...." Consultant, Physician Associate etc.” (Anonymous respondent).

Organisational Issues

- “Need to make process as easy as possible for the public. A lot of the concerns may be related to communication and processes; therefore, this process needs to reflect that.” (Individual, LM).

- “The actual complaints procedure is not self-explanatory. A step-by-step instruction would be helpful.” (Individual, AS).

- “RCN Wales would also support the establishment of a role of a named complaint lead in the relevant organisation or provider, as this would help in ensuring that oversight and governance of processes are adhered to.” (Royal College of Nursing Wales).

Timing and Access

- “We would also wish to emphasise that most clinicians are exceptionally busy with their frontline duties and therefore have limited time for writing complaint reports- which are often required to be extremely detailed- and the time pressures on clinical staff must be factored into any effective complaints system to ensure that patients are provided with as comprehensive a report as possible.” (Royal College of Physicians of Edinburgh).

- “Very rarely does a Health Board meet its deadline for providing their response. For that reason, we are of the view the process of investigating a concern needs to be thoroughly reviewed and the cause(s) of these delays identified before any extension to the threshold is implemented. As raised in our earlier responses, conversations we have with staff within the Concerns Teams at various Health Boards suggest that the departments are often understaffed and already overwhelmed by the number of investigations within the current threshold of £25,000.” (Thompsons Solicitors).

Continuous Improvement

- “Complaints and learning from complaints should be looked at on a national footprint and complainants informed that this is happening and will inform change.” (Betsi Cadwaladr, Primary Care Clinical Governance)

- “The review and commitment to NHS staff training would be welcomed. Need to ensure all the relevant staff involved in PTR are mandated to attend training. It would be helpful to have the training supported with how to guides, webinars, podcasts for ongoing reference." (The Royal College of Midwives).

Conclusion/Next Steps

NHS care in Wales is complex both in the nature of the care people need today and in the map of services and provider organisations delivering care in Wales. It is therefore imperative we have a modern system of raising concerns and responding to them that is fit for purpose both for now and for the future generations.

The consultation feedback was clear in that the current process either in its design or its operation is not working for a great many of those who have reason to raise a complaint.

Lengthy delays and protracted investigations are compounded by a confusing and difficult system to navigate. Many respondents feel let down and lost in the system and this must change. It is clear that the volume of complaints in the system is a factor and patients and those who raise complaints on behalf of another cite that their specific concerns raised in the complaint are often not answered fully or clearly.

The experience of some complainants is not of transparency and openness with clear accountability for things that have not gone right but an impression of defensiveness and a lack of honesty and cover up. The consultation responses also highlighted a disconnect between what the regulations force organisations to do that at times can be in direct conflict to the resolution requested by the complainant. This is further compounded by the significant length of time it takes for many complaints to be even responded to. This must change. The NHS in Wales must take urgent action to recover this position and change its approach.

The Public Services Ombudsman for Wales published the *Groundhog Day 2* report in 2023[10] demonstrating the key themes and learning from complaint process analysis and the impact of poorly answered complaints have on individuals

"When public bodies respond to complaints poorly and defensively, sometimes after a lengthy complaints process, they compound the feeling of injustice that prompted people to complain in the first place" – PSOW 2023.

The changes proposed from this consultation aim to improve the system of raising and responding to complaints and refresh the understanding, instigate a re-focus on listening to people and learning lessons to improve care.

The next steps that will be taken will be that the Welsh Government policy team will work on developing amending regulations and guidance and developing with the NHS an implementation plan alongside producing support training materials and those specifically aimed at the public.

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[10] https://www.ombudsman.wales/blog/2023/06/15/today-we-publish-our-special-report-groundhog-day-2/

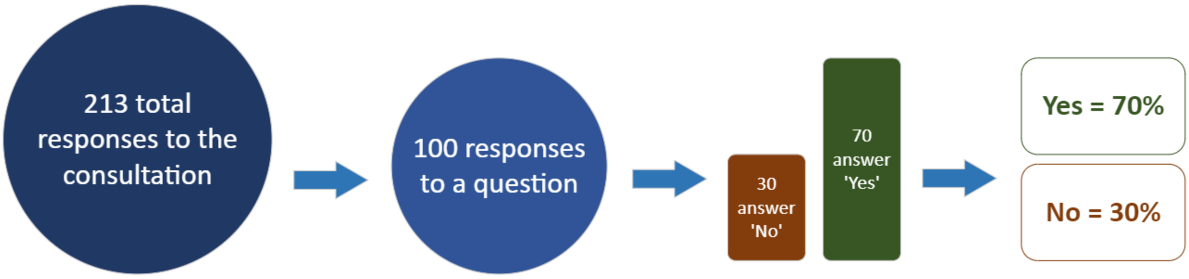
The Welsh Government want to finally thank those who took the time to share with us their candid, often very personal, and painful experiences of raising a complaint with the Welsh NHS.

Appendices

Appendix A: Analysis Methodology

Data Collection and Quantitative Analysis

Consultation responses were submitted via the Smart Survey portal, email, or post. All responses (apart from 20 which were received after the portal closure date), irrespective of their format were submitted into the online portal to ensure a complete data set with consistent formatting for analysis. The seven responses that were received after the portal closure date were considered within the analysis and added to the data set retrospectively. In total, 213 consultation responses were considered as part of the analysis with 167 complete responses and 46 incomplete responses (see 'Summary of Respondents' for more details). For this analysis, an incomplete response was defined as a response where at least one question of the consultation was answered, but the individual did not submit their answers at the end of the process. The feedback provided within the incomplete responses was considered as part of the analysis. However, where we have outlined the percentage of respondents that answered yes or no to each question, this percentage is out of the number of respondents that answered that question, rather than 213 total respondents (example below).



Appendix A graphic 1: An example of how Yes/No percentages were calculated.

All data from the consultation was collated and formatted into one data source to complete an initial quantitative analysis. This provided an early opportunity to present the 'yes/no' response rate to each question, which subsequently highlighted questions where there was a disparity in responses and areas that may have needed to be considered further. At this point, all respondents' details, whether they represented themselves or an organisation in their response and whether or not they would like to remain anonymous was collected into the data source. Although no additional weighting was provided to responses, irrespective of whether they were from an individual or organisation, it did provide the opportunity for further insight and to see if there was any disparity in responses by organisation and individuals.

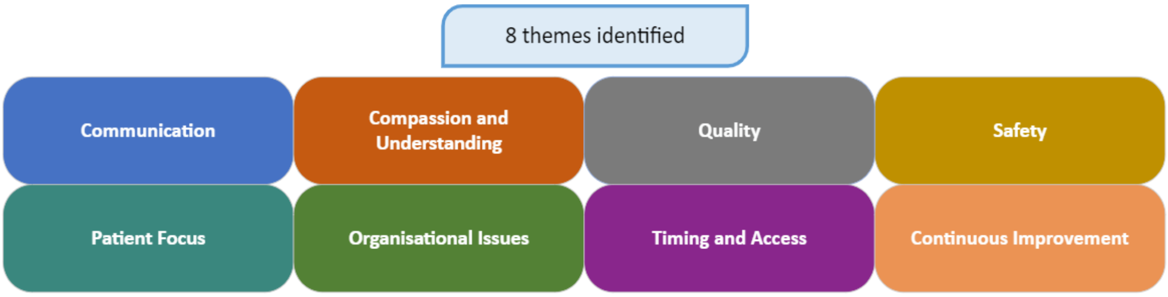
Following the initial quantitative analysis, all comments provided in response to the 25-question consultation were collated, along with the; question number, question,

question chapter, respondent ID and their ‘yes/no’ response (or in the case of question 5, the multiple-choice response).

Qualitative Analysis

A hybrid approach was undertaken for the qualitative analysis of narrative responses, combining inductive and deductive methods. Prior to reviewing and considering each comment provided by respondents, the deductive approach was informed by the findings of Reader et al in their paper, “Patient complaints in healthcare systems: a systematic review and coding taxonomy” (Reader TW, et al)[11][12][13]. Whilst it was recognised that the Reader et al paper concentrated on the coding of patient complaints and this consultation was aimed to attain the “views on the way concerns and complaints about NHS care are raised, investigated, and responded to”(Welsh Government, 2024)[14], it was felt that the categories outlined in the Reader et al paper could be used as an initial indicator of what themes may arise in responses to the Putting Things Right consultation. With a hypothesis of the themes that would arise, an inductive method of analysis was then used to generate the most suitable themes for the data from the Putting Things Right consultation.

The inductive approach began by reviewing and carefully considering the personal experiences shared in response to question 1 and 25 of the consultation. Each response was reviewed and considered in detail and themes were identified from the stories that were shared. Subsequently, the responses to all other questions were reviewed to ensure that the themes arising from question 1 and 25 were consistent throughout the consultation responses. This hybrid deductive and inductive approach allowed for the flexibility to consider previous research and the data that was available as part of the consultation, and this resulted in eight themes being identified (please see Annex C for more information).



Appendix A graphic 2: Themes identified within PTR consultation analysis.

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[11] TW Reader, A Gillespie, J Roberts (2014). Patient complaints in healthcare systems: a systematic review and coding taxonomy. *British Medical Journal*, 23: 678-689.

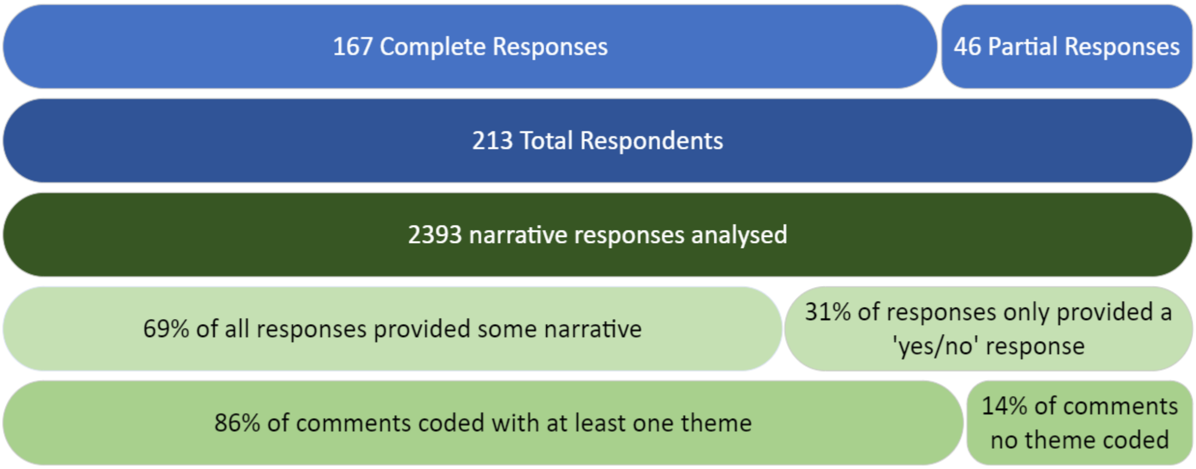
[12] Gillespie, A, Reader TW (2016). The Healthcare Complaints Analysis Tool: development and reliability testing of a method for service monitoring and organisational learning. British Medical Journal, 25: 937-946

[13] van Dael J, Reader TW, Gillespie A, Neves AL, Darzi A, Mayer EK (2020). Learning from complaints in healthcare: a realist review of academic literature, policy evidence and front-line insights. British Medical Journal, 29: 684-695

[14] Proposed changes to the Putting Things Right process. (2024, February 12). Retrieved from Welsh Government: https://www.gov.wales/proposed-changes-putting-things-right-process

Whilst the categories outlined by Reader et al shared similarities with the themes identified in the consultation responses, the feedback from the consultation has played a crucial role in refining and expanding the themes used throughout this analysis. The insights from the consultation responses have not only validated some of the existing categories proposed by Reader et al but have also led to the emergence of new themes. The inductive method also supported the creation of a list of sub-themes derived from the eight themes, these sub-themes supported the coding exercise and offered further insight into the consultation responses. In addition, another reviewer undertook a visual check of the themes against the comments received, which provided a consensus that the themes generated were appropriate. This iterative process ensured our analysis remained grounded in the data while also building upon established research.

Coding of Responses



Appendix A graphic 3: Response, respondent and coding breakdown.

The next step undertaken was the coding of respondent’s comments. There was a total of 213 complete (167) and incomplete (46) responses which resulted in 2393 comments to be analysed. This process involved assigning key words and phrases to each theme and sub-theme, and then an initial content analysis was completed on the narrative responses to highlight which themes and sub-themes were present within each comment. To ensure the validity of the content analysis, each comment was manually reviewed to confirm the correct interpretation of context. If a theme or sub-theme was found to be not applicable in the given context, it was updated or removed accordingly. In total, 69% of all responses to the consultation included a narrative response with the remaining 31% only providing a ‘yes/no’ response. Of the 2393 narrative responses, 86% were coded with at least one theme. The fact that such a high percentage of responses could be coded suggests that our coding scheme was effective and robust. However, the ultimate measure of its success will be the insightfulness of the overall analysis. Due to the narrative nature of the responses, we decided that coding more than one theme per narrative response would be necessary, so that there is a true thematic reflection of the comment in the analysis. Because more than one theme could be attached to each comment, the decision was made to present the data by the percentage of comments where each theme was present, per question or chapter.

Presentation of Findings

Once the coding process was completed, the data and findings were presented in Microsoft Power BI. We presented the qualitative and quantitative data in one Power BI report, whilst also being able to filter the responses by chapter, question, respondent type, 'yes/no' answer and whether the response was complete or partial. It also provided the opportunity to highlight the themes and sub-themes that arose within each chapter and question. Whilst also being able to interrogate the data at a more granular level, by viewing each narrative response provided and the theme and sub-theme that had been coded to that comment.

Appendix B: Summary of Respondents

In total the Putting Things Right consultation generated 170 completed and 176 partial responses. For this analysis, a complete response is defined as a response whereby the respondent navigated to the end of the consultation and selected submit, with the majority, but not all questions answered. A partial response is defined as a response whereby the respondent opened the consultation but did not get to the end of the consultation and select submit.

150 completed responses were received via the Smart Survey portal or added into the portal, an additional 20 responses were received after the portal closure date and 3 responses were omitted. This resulted in 167 completed responses being considered within the analysis. A breakdown of those responses is outlined below:

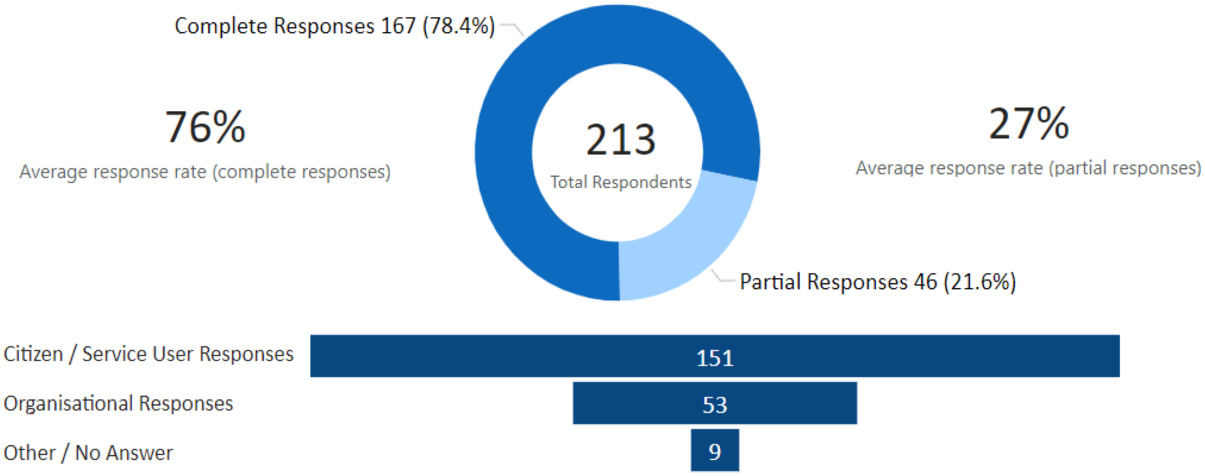
- 150 completed responses within the Smart Survey portal.
- 20 completed responses were received after the portal closure date but were considered within the analysis.
- 1 completely blank response which has been omitted from the analysis.
- 2 duplicate responses which were also omitted from the analysis.

There were 58 responses submitted by email or post, and the remaining 112 were submitted via the Smart Survey portal (this includes the three omitted responses). All respondents were asked if there were responding on behalf of an organisation or as an individual, a breakdown of those responses is provided below:

- 109 responses from individuals
- 50 responses from organisations (breakdown below)
    - 11 NHS representatives/organisations. e.g. Health boards or NHS trusts
    - 15 charities/non-profit/voluntary/advocacy organisations
    - 8 legal associations
    - 8 professional associations (exc. legal)
    - 3 independent providers

    - 3 local authorities or community councils
    - 1 primary care provider; and
    - 1 respondent did not highlight their organisation.
- 8 respondents answered ‘Other’ or did not answer this question.

Of the 154 complete responses considered within the analysis, there was an average response rate to all questions of 83%. However, the average response rate is influenced by ‘Easy-read’ submissions (11 ‘Easy-read’ responses) as this method of response only provided the opportunity to answer 14 questions, in comparison to the 25 questions in the full consultation.



Appendix B graphic 1: Breakdown of respondents.

There were 176 partial responses in the Smart Survey portal, however only partial responses where at least one question of the consultation was answered were considered within the analysis. This resulted in 46 partial responses being considered within the analysis; a breakdown of all partial responses is provided below:

- 46 of the partial responses answered at least one question.
- 56 submitted personal details (name, address, organisation etc.); these responses were omitted from the analysis.
- 55 were completely blank responses; these responses were omitted from the analysis.
- 19 were duplicate responses and were subsequently omitted from the analysis.

Of the partial responses that were considered within the analysis (46), the average response rate to all questions was 27%. However, the response rate was considerably higher for question 1, where respondents were asked to share their own experiences, with a response rate of 76%.

In summary, the total number of responses that were considered as part of the analysis was 213, with the breakdown provided highlighted in ‘Appendix B graphic 1’ (above).

Respondent ID	Name of Respondent	Type of Respondent
237620850	Name not provided.	Citizen/Service User
237662555	Anonymous	Citizen/Service User
237675361	Anonymous	Citizen/Service User
237687316	Anonymous	Citizen/Service User
237721981	Anonymous	Citizen/Service User
237810000	Eleri Evans	Citizen/Service User
237841909	Teresa Margaret Harris	Not specified/other
237863977	Anonymous	Citizen/Service User
237884413	Naomi Holder, Betsi Cadwaladr University Health Board	NHS professional/organisation representative
237896218	Anonymous	Citizen/Service User
237998463	Beverly Jenkins	Citizen/Service User
238023373	Name not provided.	Not specified/other
238032897	Anonymous	Citizen/Service User
238040022	Anonymous	Citizen/Service User
238057310	Sarah Dean	Citizen/Service User
238063034	Anonymous	Citizen/Service User
238163876	Name not provided.	Not specified/other
238228644	Anonymous	Citizen/Service User
238250057	Anonymous	Citizen/Service User
238273602	Anonymous	Citizen/Service User
238395752	Anonymous	Citizen/Service User
238469144	Name not provided.	Not specified.
238493445	Anonymous	Citizen/Service User
238506399	Sue Jones	Citizen/Service User
238507474	Anonymous	Citizen/Service User
238509031	Anonymous	Citizen/Service User
238516237	Anonymous	Citizen/Service User
238549818	Anonymous	Citizen/Service User
238585460	Jodie Pentney	Citizen/Service User
238591506	Anonymous	Citizen/Service User
238668755	Anonymous	Citizen/Service User
238688534	Anonymous	Citizen/Service User
238797134	Anonymous	Citizen/Service User
238823888	Anonymous	Citizen/Service User
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238959427	Anonymous	Citizen/Service User
239330613	Anonymous	Citizen/Service User
239360049	Anonymous	Citizen/Service User
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239442005	Katie Waldron	Citizen/Service User
239520327	Anonymous	NHS professional/organisation representative
239773511	Anonymous	Citizen/Service User
240107209	Anonymous	Citizen/Service User

240490000	Jemaimah Morgan	Citizen/Service User
240489832	Anonymous	Citizen/Service User
240529276	Anonymous	Citizen/Service User
240666206	Anonymous	Citizen/Service User
240723596	Anonymous	Citizen/Service User
240768466	Gillian Read	Citizen/Service User
240781819	Anonymous	Citizen/Service User
240803843	Anonymous	Citizen/Service User
241055437	Stephen Robbins	Citizen/Service User
241056747	Anonymous	Citizen/Service User
241058553	Lesley McNeill	Not specified/other
241059780	Julie Thomas	Not specified/other
241137620	Mary Barratt, Betsi Cadwaladr University Health Board	NHS professional/organisation representative
241435645	Anonymous	Citizen/Service User
241456321	Phillippa Reeks	Citizen/Service User
241502478	Anonymous	Citizen/Service User
241506565	Eleanor Jones	Citizen/Service User
241513470	Anonymous	Citizen/Service User
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241519246	Emma Clatworthy	Citizen/Service User
241579004	Anonymous	Citizen/Service User
241587343	Stuart Crosby	Citizen/Service User
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241951351	Anonymous	Citizen/Service User
241953971	Anonymous	Citizen/Service User
241959778	Zoe Kate Ashman, Powys Teaching Health Board	NHS professional/organisation representative
241960492	Catherine Ann Dowling, NHS Executive Performance and Assurance	NHS professional/organisation representative
241965644	Anonymous	Citizen/Service User
241989308	Anonymous	Citizen/Service User
242007926	Anonymous	Citizen/Service User
242022986	Anonymous	NHS professional/organisation representative
242033540	Anonymous	NHS professional/organisation representative
242041933	Annette Evans	Citizen/Service User
242086923	Anonymous	Citizen/Service User
242090606	Anonymous	Citizen/Service User
242092945	Anonymous	Citizen/Service User
242108397	Teresa Harris	Citizen/Service User
242161558	Lisa Parrin-Lester	Citizen/Service User
242166459	Anonymous	Independent provider representative/organisation

242178331	Anonymous	Charity/non-profit/voluntary/advocacy organisation/representative
242282085	Raywn Law	Citizen/Service User
242289234	Amanda Scarfe	Citizen/Service User
242297948	Terry Grady	Citizen/Service User
242374836	Steve Simmonds, Community Pharmacy Wales	Independent provider representative/organisation
242410989	Anonymous	Citizen/Service User
242440225	Helen Wilson	Citizen/Service User
242466909	Douglas Pattullo, The Royal College of Physicians of Edinburgh	Professional association/representative (exc. legal)
242614252	Gareth Parry	Citizen/Service User
242627021	Anonymous	Primary care organisation/representative
242734239	Anonymous	Citizen/Service User
242870730	Anonymous	Citizen/Service User
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242993687	Anonymous	Citizen/Service User
243011860	Nikki Hughes-McLeod	Citizen/Service User
243014130	Steven Skivens, Penyrheol Trecenydd and Energlyn Community Council	Local authority or community council/representative
243024377	Anonymous	Citizen/Service User
243030126	Eryl Lewis Jones	Citizen/Service User
243030616	Betsi Cadwaladr, Primary Care Clinical Governance	NHS professional/organisation representative
243034577	Anonymous	Citizen/Service User
243035605	Anonymous	Citizen/Service User
243046011	Anonymous	Citizen/Service User
243057451	Susan Jones	Citizen/Service User
243066981	Joanna Cahill	Citizen/Service User
243071592	Anonymous	Citizen/Service User
243107719	Anonymous	Citizen/Service User
243201989	Anonymous	Citizen/Service User
243278591	Diana Russell	Citizen/Service User
243285810	Peter Roberts	Citizen/Service User
243305291	Anonymous	Citizen/Service User
243305175	Janis Lesley Griffiths	Citizen/Service User
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243402419	Anonymous	Citizen/Service User
243409445	Gethin J Brown	Citizen/Service User
243445676	Anonymous	Citizen/Service User
243487549	Association of Personal Injury Lawyers (APIL)	Legal association/representative
243493724	Dr Luke John Davies, The Royal College of Surgeons of Edinburgh	Professional association/representative (exc. legal)
243497051	Anonymous	Charity/non-profit/voluntary/advocacy organisation/representative
243536556	Stephen Stirk	Citizen/Service User
243542250	Anonymous	Local authority or community council/representative
243597547	Anonymous	Citizen/Service User
243657904	Anonymous	Legal association/representative
243702589	Anonymous	NHS professional/organisation representative
243724017	Judith Brooks, Merthyr Tydfil County Borough Council	Local authority or community council/representative
243750361	Anonymous	Citizen/Service User
243777687	Julie Matthews	Citizen/Service User
243779263	Anonymous	Citizen/Service User
243793135	Anonymous	Citizen/Service User
243813797	Julie Grayston, Graystons Solicitors	Legal association/representative
243834708	Gillian Carruthers	Citizen/Service User
243835654	Anonymous	Citizen/Service User
243836970	Anonymous	Citizen/Service User
243853817	Kathie Jones	Citizen/Service User
243858485	Maureen Morecombe	Citizen/Service User
243861590	Anonymous	Citizen/Service User
243870144	Anonymous	Citizen/Service User
243877802	Maureen Carol Smith	Citizen/Service User
243879814	Grace Coppock, All Wales Forum of Parents and Carers of People with Learning Disabilities	Charity/non-profit/voluntary/advocacy organisation/representative
243888573	Anonymous	Citizen/Service User
243893165	Helen Twidle, Age Cymru	Charity/non-profit/voluntary/advocacy organisation/representative
243899582	Anonymous	Citizen/Service User
243906157	Anonymous	Citizen/Service User
244217928	Annette Hannington	Citizen/Service User
244218491	Councillor Kevin Etheridge, County Councillor for Blackwood	Not specified/other
244220422	Rosemary Flowers-Wanjie, The Health and Care Professions Council (HCPC)	Professional association/representative (exc. legal)

244220925	Victoria Gofton, Thompsons Solicitors	Legal association/representative
244221297	Coleg Nyrsio Brenhinol Cymru – Royal College of Nursing Wales	Professional association/representative (exc. legal)
244221941	Anonymous	Citizen/Service User
244222624	Lynda Reynolds, Society of Clinical Injury Lawyers	Legal association/representative
244224539	Older People’s Commissioner for Wales	Charity/non-profit/voluntary/advocacy organisation/representative
244228133	British Medical Association Cymru Wales	Professional association/representative (exc. legal)
244230611	Christopher Williams, Age Alliance Wales	Charity/non-profit/voluntary/advocacy organisation/representative
244231339	Greg Pycrof, Tenovus Cancer Care	Charity/non-profit/voluntary/advocacy organisation/representative
244234056	Name not provided.	Not specified/other
244234217	Dr P H G Penny, Mitcheltroy United Community Council	Local authority or community council/representative
244235566	Sarah Dowsell, ABUHB - Endoscopy Deputy Nurse Manager RGH/GUH	NHS professional/organisation representative
244235971	Michael Hooton	Citizen/Service User
244236509	Anonymous	Charity/non-profit/voluntary/advocacy organisation/representative
244237016	Anonymous	Citizen/Service User
244369227	Mari Rosser, Hugh James	Legal association/representative
244369795	Rocio Cifuentes MBE, Children’s Commissioner for Wales	Charity/non-profit/voluntary/advocacy organisation/representative
244370501	Aled Blake, Learning Disability Wales	Charity/non-profit/voluntary/advocacy organisation/representative
244371012	Haleema Khan, Policy, and Public Affairs Officer, The Welsh NHS Confederation	Professional association/representative (exc. legal)
244371638	Joshua Lovell, General Medical Council	Professional association/representative (exc. legal)
244372328	Jane Scully	Citizen/Service User
244372714	Alicia Johns, Lanyon Bowdler LLP	Legal association/representative
244373116	Rachel Rowlands, Age Connects Morgannwg	Charity/non-profit/voluntary/advocacy organisation/representative
244374162	Vicky Richards, The Royal College of Midwives	Professional association/representative (exc. legal)
244381002	Natasha Wynne, Marie Curie	Charity/non-profit/voluntary/advocacy organisation/representative
244381392	Anonymous	Citizen/Service User
244381616	Jake Smith, Carers Wales	Charity/non-profit/voluntary/advocacy organisation/representative
244381907	FTWW: Fair Treatment for the Women of Wales	Charity/non-profit/voluntary/advocacy organisation/representative

244382491	Public Services Ombudsman for Wales	Charity/non-profit/voluntary/advocacy organisation/representative
244383380	Llais	Charity/non-profit/voluntary/advocacy organisation/representative
244384361	Mencap Cymru and the Paul Ridd Foundation	Charity/non-profit/voluntary/advocacy organisation/representative
244386537	Action against Medical Accidents (AvMA)	Legal association/representative
244388287	Dawn Bowden MS, Member for Merthyr Tydfil and Rhymney	Not specified/other
244416601	Angela Hughes, Cardiff and Vale University Health Board	NHS professional/organisation representative
244831787	Claire Appleton, Welsh Ambulance Services Trust	NHS professional/organisation representative
244831789	Anonymous	NHS professional/organisation representative
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244831808	Anonymous	Citizen/Service User

Appendix C: Identified theme and sub-theme definitions

Theme(s)	Definition
Timing and Access	The respondent underlined an issue with timescales, delays or access to information or services.
Organisational Issues	The respondent highlighted an organisational issue such as unsuitable/unclear guidance and processes, insufficient finances, staffing or resources.
Continuous Improvement	The respondent felt that additional training is required or felt that lessons learnt should be considered to improve the service.
Communication	The respondent highlighted that there has been a communication breakdown, alternative communication methods should be considered, or patient-staff dialogue needs to be improved.
Compassion and understanding	The respondent highlighted that communication needed to be compassionate, and professionals needed to take the time to understand concerns raised.
Patient Focus	The respondent highlighted that the patient/individual and their rights should be at the centre of any decision, there needs to be additional support highlighted/put in place or the respondent underlines a negative patient experience.
Quality	The respondent highlighted poor treatment or quality of care in their response. Or felt that quality outcomes for the induvial should be the aim of the proposal and process.
Safety	The respondent highlighted that there has been a safety incident, or concerns are raised around skills and conduct of staff.

Theme	Sub Theme	Definition
Timing and Access	Access to services and information (including legal advice)	The respondent highlighted that there is an issue with accessing information or services, including legal aid or advice.
	Timescales	The respondent highlighted that timescales need to be clearly outlined and adhered to.
	Delays	The respondent highlighted that there has been a delay, or the proposal could cause further delays.
	Early resolution	The respondent highlighted that early resolution should be the aim/or would be the best outcome.
Organisational Issues	Guidance and processes	The respondent highlighted an issue with guidance, processes or procedures or suggested that further policies/regulations should be considered.
	Finances	The respondent highlighted that finances could be or are currently an issue.
	Staffing and resources	The respondent highlighted that staffing and resources need to be considered, or capacity may be a concern.
	Accountability	The respondent highlighted that there needed to be accountability when complaints are made.
	Service issues	The respondent highlighted an issue with a service within the health organisation.
Continuous Improvement	Training	The respondent highlighted that further training would need to be provided to ensure that the changes could be implemented.
	Improvement	The respondent highlighted that improvements are required with the health organisation.
	Lessons learnt	The respondent highlighted that lessons learnt should be used to inform future decisions and stop issues occurring again.
Communication	Communication breakdown	The respondent highlighted that there has been/or will be a concern that a communication breakdown will occur.
	Point of contact	The respondent highlighted that a point of contact should be made available for the complainant.
	Effective communication methods	The respondent highlighted that effective communication methods need to be used to ensure that information is shared and understood.

	Patient-staff dialogue	The respondent highlighted that there needed to be transparency, openness and they should feel heard when communicating with staff.
Compassion and understanding	Respect, dignity and caring	The respondent highlighted that there needed to be compassion, respect and understanding during the process.
Patient Focus	Patient centred	The respondent highlighted that any proposal should be patient or person centred.
	Patient experience	The respondent highlighted a negative experience; a time where they have experienced stress, anxiety or frustration for example.
	Patient support	The respondent highlighted that support needs to be made available for individuals, or they should be signposted to support that can be provided.
	Patient rights	The respondent highlighted that patient and individual’s rights should be considered within the proposal.
Quality	Treatment	The respondent highlighted an issue with treatment received, or potential issues with treatment.
	Quality of Care	The respondent highlighted a concern with the quality of care they or a family member has received.
	Outcomes	The respondent highlighted that it is important that the individuals achieve closure, have their questions answered or their complaint should be resolved.
Safety	Skills and conduct	The respondent highlighted that there was an issue or concern with the skills or conduct of staff.
	Safety incidents	The respondent highlighted that there has been a safety incident which has happened because of a mistake, error or failure which results in a negative outcome for the individual.