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Groundhog Day 2: An opportunity for cultural change in complaint handling?

June 2023

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Groundhog Day 2: An opportunity for cultural change in complaint handling?

The Ombudsman is publishing this report as an extraordinary report in accordance with paragraph 15 of Schedule 1 of the Public Services Ombudsman (Wales) Act 2019.

Foreword

This is the first Thematic Report I have issued since being appointed as the Public Services Ombudsman for Wales in April 2022.

During my first year as Ombudsman, I have been struck by the similar pattern of complaint handling failings which my office has identified in cases involving Health Boards across Wales.

In March 2017, my predecessor issued a Thematic Report 'Ending Groundhog Day: Lessons from Poor Complaint Handling.'

The lessons highlighted in that report remain relevant today. All too often, public bodies respond to complaints defensively rather than seeing them as an opportunity for learning and improving the services they deliver. This report focusses on cases involving Health Boards in Wales, which represent a significant proportion of the complaints made to my office.

The new 'Duty of Candour' on health organisations in Wales, which was introduced on 1 April 2023, requires them to be open and transparent with service users when they experience harm whilst receiving health care. This duty provides a fresh opportunity for cultural change - to promote candour and openness with service users and ensure there is systemic learning when things have gone wrong.

Although most health care across Wales is delivered in an excellent and professional manner, inevitably, sometimes organisations make mistakes. When mistakes happen, we expect health bodies to respond openly and honestly to patients and their families.

This ethos underpins our work as Complaints Standards Authority for Wales. Our statutory Guidance to public bodies in Wales: 'Principles of Good Administration' outlines that "putting things right" is a key principle of good administration, which includes investigating complaints thoroughly and acknowledging when things go wrong.

Our complaints standards training to Health Boards and the requirements of the Duty of Candour provide a fresh opportunity for changes to the ways in which health bodies engage with their patients and respond to complaints.

I hope that the guidance and lessons highlighted in this Report will be helpful and will remind Health Boards why honesty and openness is so important when responding to complaints.

Michelle Morris
Public Services
Ombudsman for Wales

15 June 2023

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Our role

As the Public Services Ombudsman for Wales, we have legal powers to look at complaints about public services.

We can look at complaints about all health care providers and independent care providers in Wales, including Health Boards, Trusts, GPs and dentists.

We have a team of people who consider and investigate complaints.

We are independent of all government bodies and our service is impartial and free of charge.

Background

Introduction

When we issued the first 'Groundhog Day' report, our aim was to highlight to public bodies in Wales that the complaints they receive provide an opportunity for learning and improvement. We also wanted to show that, all too often, we have seen that public bodies have been overly defensive and not objective enough when responding to complaints.

We also highlighted that, in too many cases, when organisations made mistakes, they made the situation worse by not looking into complaints correctly. We urged public bodies to embrace the cultural change which was needed to ensure that they learned from complaints and improved services. Although we see many examples of good practice in complaint handling, evidence from our casework suggests that more needs to be done. This is especially true in relation to health complaints which are handled by Health Boards.

The 'Duty of Candour' was introduced in addition to the 'Duty of Quality', which requires NHS organisations (and Welsh Ministers) to take new steps to improve the quality of health services.[1] The overarching aim of the Duty of Candour is to ensure that a person receiving care from the NHS (or from a regulated provider of health care services) can have confidence that they will be dealt with in an open, transparent and honest way. If something goes wrong, they should be told about it, receive an apology, offered support and be assured that their issue will be investigated properly, under the Putting Things Right scheme.[2]

Under the Duties of Quality and Candour, Health Boards must report every year on how they comply with these duties. Quality and Patient Safety Committees within Health Boards also have a role in ensuring that the Health Boards discharge these duties, learn lessons and escalate concerns to the Board, if appropriate.

The learning from our cases should also inform NHS bodies' assessments of how effectively they are complying with the Duty of Candour. If, for example, we find that an NHS body has not complied with the Duty of Candour in relation to any individual complaint, this should form part of the Board's monitoring and assurance processes.

This is what we would like to see when we consider how public bodies have handled complaints.

1 Appendix 2 – explanation of Duties of Candour and Quality

2 Appendix 2 – explanation of the NHS Complaints Process: the Putting Things Right scheme

People who contact us want organisations to put things right for them; however, sometimes, even more importantly, they also want to make sure that the same issue will not affect someone else in the future.

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. It is also exhausting for complainants to have to escalate their concerns to us. The way in which organisations deal with complaints is very important and can make a huge difference to people's experiences and to their ongoing relationship with, and trust in, their care provider and public services.

Our work as Complaints Standard Authority

Since our original 'Groundhog Day' report, we have used our proactive powers under the Public Services Ombudsman (Wales) Act 2019, to publish our Statement of Principles for complaints handling by public bodies. These include our expectation that effective complaints handling processes should be fair and objective, accountable and committed to continuous improvement.

We have also supported Health Boards by providing extensive training in complaint handling for their staff and begun capturing data from organisations about the complaints they deal with under the NHS complaints procedure: the 'Putting Things Right scheme' ('PTR'). By publishing this data, we have introduced more transparency and accountability for Health Boards handling complaints.

Since February 2021, we have provided over 120 training sessions for Health Boards on Complaint Handling, Investigation Skills and Communications Skills. We now expect health bodies to reflect upon and implement this good practice.

When we uphold complaints, we may make recommendations to the relevant organisation to put things right for the person who has suffered injustice - and to ensure that the body learns from what went wrong. The case examples included in this report demonstrate how things can go wrong and why a cultural change in approach to complaint handling is needed.

Capturing data from organisations about the complaints they deal with.

Over 120 training sessions provided on Complaint Handling, Investigation Skills and Communication Skills.

Complaints about Health Boards

Complaints about health services continue to represent a large part of our work. During 2022/23, 37% of all complaints about public bodies made to us were health cases, of which 75% were about Health Boards. They accounted for 81% of the cases we investigated. This is because we often need to obtain clinical records and independent clinical advice to inform our decisions on these cases. Even on health cases that we do not fully investigate, we often agree to resolve things early.

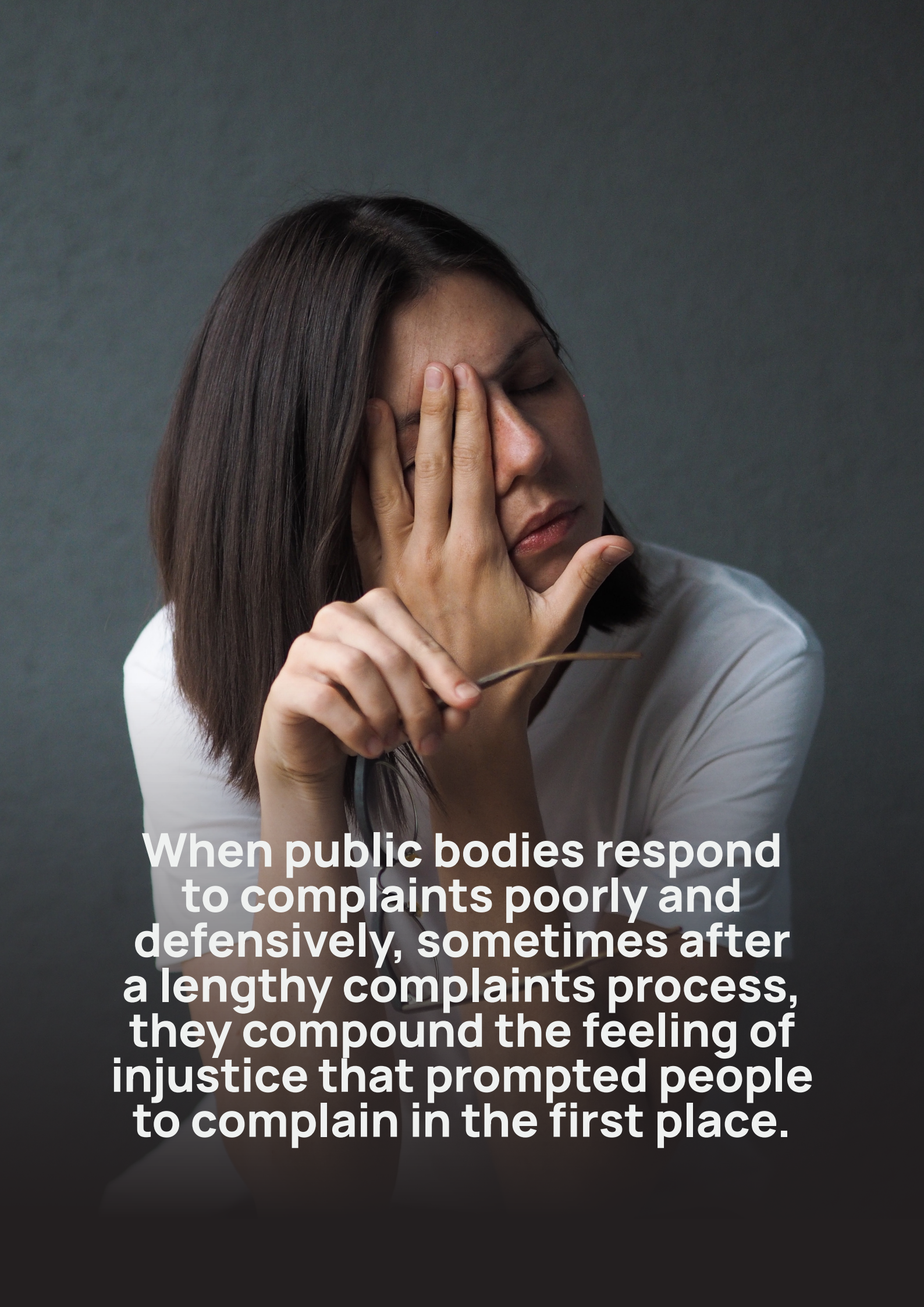
We continue to see increases in complaints about poor complaint handling by Health Boards. For example, when complaints responses are delayed or inadequate, we can recommend that a full and reasoned response is provided to the complainant. Overall, our intervention rate[3] on complaints about Health Boards we receive ranges from between 22% and 41%, depending on the Health Board area.[4]

We uphold complaints when we decide the organisation made mistakes which had a negative impact on the person who received care. We apply our Clinical Standard and consider whether the care and treatment were appropriate. We also consider the facts of the case, relevant clinical guidance or other codes of practice or policies in place at the time, as well as explanations provided by the clinician or organisation delivering the care.

The case examples (set out in full in Appendix 1) included in this report are recent cases we have determined over the last 12 months. This is a small, but representative, sample of cases which highlight the apparent lack of rigour and openness in complaints investigations. It reflects the pattern of failings we see in local investigations which are undertaken in Health Boards under the PTR scheme.

3 Our 'intervention' rate reflects an outcome in complaints in public services when we decide that something has gone wrong, and things must be put right. This could be by making recommendations or agreeing early resolution or settlement of a complaint.

4 Data on our intervention rates, early resolutions and upheld complaints per health board is in our Annual Report 2022/23.



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.

Themes & learning points

A lack of openness and candour - clear evidence of maladministration or service failure not identified during local investigations

Even when, following investigation, the facts of a case clearly show that the Health Board made a mistake, we see that organisations do not acknowledge this in their complaint responses. This should be an obvious step. That it often does not happen suggests that there is a need for cultural change for staff investigating complaints, so that they feel they can respond to and uphold complaints when the evidence supports this, in an honest and open way.

Mrs A's complaint concerned this kind of failing (**case example 2**). Even when the Betsi Cadwaladr University Health Board had acknowledged that it had not offered Mrs A's relative the bowel care she needed and had discharged her too soon, its initial response supported the discharge decision. Even when it issued a second response to the complaint, the Health Board did not acknowledge the failings fully. We considered that the initial review of the patient's care was not detailed, rigorous, open and transparent enough. This contributed to a lack of candour on the part of the Health Board.

In Mr D's complaint (**case example 3**), the Swansea Bay University Health Board acknowledged in its complaints response that there was no record of Mr D being given an appropriate discharge letter. Still, even after agreeing to our proposal for settlement, it took detailed discussions with the Health Board and its legal department for it to finally accept the modest settlement we proposed in recognition of this failure.

In Mr J's case (**case example 4**), we found that the Aneurin Bevan University Health Board had mishandled arrangements for the surgery Mr J needed. This resulted in an avoidable 5 week delay until the surgery took place (which breached the National Pathway guidelines for colorectal cancer). This had a very negative impact on Mr J. Rather than accept that it had made this mistake, the Health Board's complaint response lacked candour and openness. It was only in response to our investigation that the Health Board acknowledged that the surgery had not been booked. The Health Board should have been open with Mr J about this from the start, when it responded to his complaint.

A lack of objective review of clinical care and treatment

When we consider health complaints, we rely on advice from our clinical advisers, apply our Clinical Standard and decide whether the care and treatment provided to any individual was appropriate.

We often find that, when Health Boards respond to complaints, they have not objectively assessed the care and treatment provided. Sometimes, the individual clinicians who have delivered the care are involved in complaints responses. However, even when there has been a review of the care and treatment by other clinicians within the body, failings which are immediately apparent to our own clinical advisers were not identified during the local peer review.

When we share the clinical advice we have received with Health Boards, we find that, in most cases, our recommendations are accepted. Although we welcome this, we are concerned that this pattern suggests that the care and treatment is not reviewed openly and objectively during local investigations.

For example, despite us finding that the Cwm Taf University Health Board made serious mistakes in the case of Mrs V's relative (**case example 5**), its own investigation of Ms V's complaint did not find any failings. This was despite the case being discussed "at length" at a Surgical Clinical Governance meeting. The view at the meeting was that the patient had received "...the standard treatment, as the other surgeons would have provided...".

We found that the Health Board missed opportunities during the complaint response process to identify failings at an earlier stage and avoid the need for the patient's family to escalate their complaint to us. However, when we shared our draft report and clinical advice with the Health Board, it accepted our recommendations.

Likewise, in **case example 6,** the Cardiff and Vale University Health Board's response to Miss X's original complaint only acknowledged that the Health Board did not communicate with Miss X's family as it should have. However, its own investigation did not identify that it missed several opportunities to treat Miss X's father and that his care was not good enough – all identified by our clinical adviser. This meant that the family had to pursue their complaint through our office, causing them additional time and distress.

It is worth pointing out that we very rarely, if ever, see evidence of Health Boards considering if the person investigating the matter on their behalf requires independent medical advice to assist them during their investigation. This option is available to NHS bodies as specified in the PTR Scheme.

Sometimes, the individual clinicians who have delivered the care are involved in complaints responses.

We are concerned that the care and treatment is not always reviewed openly and objectively during local investigations.

Importance of timeliness and good communications

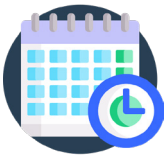
Good communication is key to ensuring that complainants do not lose trust and confidence in the complaints process. Complainants should be kept well informed throughout the complaints process and Health Boards should ensure that staff throughout the organisation understand the importance of meeting the PTR or agreed timescales for responding to complaints – staff within their complaints teams need to be well informed by their colleagues, have the support of the Health Board as a whole and have the capacity and resources to respond in a timely way.

In Mr T's case (**case example 1**), it took our intervention and over 16 months for the Hywel Dda University Health Board to respond to Mr T's complaint about the care his late mother received. This delay was well beyond the 30 day time limit, or 6-month time scale (for complex cases), set out in the PTR Scheme. This was wholly unacceptable and distressing for Mr T at a time when he was also grieving for the loss of his mother. Mr T explained to us how the ongoing delay had affected him personally and his family.

Such delays are especially concerning when complaints raise concerns about the care provided to a family member before they died. Families are entitled to receive answers to their concerns and sufficient resource should be dedicated to complaint handling within Health Boards.

In Mr T's case, and in many others we see, even after we have intervened in cases, Health Boards do not respond to complaints in line with the timescales agreed with us and complainants are not kept well informed about the reasons for this.

Complainants should be kept well informed throughout the complaints process.



Health Boards should ensure that staff throughout the organisation understand the importance of meeting the PTR or agreed timescales.

Acting fairly and proportionately – the need for robust investigations

Health Boards should give complainants a reasoned explanation, so that it is clear why they made a decision and on what facts they drew their conclusions. All of the case examples included in this report provide examples of Health Boards failing to ensure that they robustly investigated complaints and delivered fair outcomes for complainants, in line with the PTR scheme.

Health Boards should always carefully establish the facts of any case. Before coming to a decision, they should consider the evidence from the complainant and the accounts of staff members who delivered the care. This is especially important in cases when there has been a loss of life. Otherwise, complainants may completely lose trust in the investigation process and the outcome of their complaint.

Future considerations

As Health Boards across Wales embrace and implement their organisational Duty of Candour, we trust that the themes outlined in this report will provide a timely reminder of lessons which they should learn from our recent complaints.

The organisational Duty of Candour on Health Boards should also bring a cultural change to the way in which Health Boards respond to complaints and concerns. If we see that a Health Board made an error that had a negative impact on the complainant, we can recommend that it reviews how it has handled the complaint, in line with the Duty.

Also, when Health Boards' Quality and Patient Safety Committees review how effectively they have complied with the Duty, we expect them to consider details of any cases we have settled or upheld when we consider the Duty of Candour should have been engaged. Learning from our cases should also be included in Health Boards' annual reports on how effectively they have complied with the Duty of Candour and form part of Health Boards' wider monitoring and assurance processes.

Consideration of the Duty of Candour may be appropriate at all stages of our process:

- **at assessment stage**, when we are agreeing an early resolution of a complaint
- **when we have started an investigation** and we are agreeing a voluntary settlement with the body and discontinuing our investigation
- **when we have fully investigated a complaint** and we are issuing a public interest or non-public interest report.

We recommend that this report is shared with Quality & Patient Safety Committees in Health Boards and that they:

- review the resources available to complaints teams in their Health Board
- consider whether the option to provide staff investigating complaints with independent medical advice, is considered on a case by case basis
- reflect upon the lessons highlighted in this report when scrutinising their performance on complaint handling
- ensure that lessons learned from the PSOW's findings and recommendations are included in their Health Board's annual report on the Duty of Candour and Quality.

We trust that the Duty of Candour will have a positive and transformational impact on the way in which complaints are handled within Health Boards.

Appendix 1

Case example 1

Mr T's complaint (202206990 & 20230420)

Hywel Dda University Health Board

In December 2021, Mr T complained to the Hywel Dda University Health Board about the treatment his late mother received when in hospital. In his complaint to us, Mr T explained how the loss of his mother had affected him and that it was unacceptable that the Health Board had not responded to his complaint. He had been waiting for a response for 13 months before he first contacted us in February 2023.

Because of that significant delay, we agreed an early settlement of the complaint with the Health Board. The Health Board agreed to pay Mr T £250 in recognition of the delay and to respond to his complaint within four weeks (by 20 March).

The Health Board then contacted us requesting more time because a senior member of staff had identified an issue which needed to be resolved before the Health Board could respond. We agreed that the Health Board could have 3 more weeks (by 7 April), if it apologised again to Mr T and explained the reason for the further delay.

On 5 April, the Health Board contacted us again to say that it still could not issue its complaint response to Mr T.

The Health Board agreed to make a further payment of £100 to Mr T in recognition of the ongoing unacceptable delay and to issue its complaint response to Mr T by 28 April, which it then complied with.

Case example 2

Mrs A's complaint (202101000)

Betsi Cadwalladr University Health Board

Mrs A complained about the care her late sister, Ms B, received at Ysbyty Glan Clwyd ("the Hospital", within Betsi Cadwaladr University Health Board) between May 2019 and May 2020.

Mrs A was concerned that her sister did not receive appropriate bowel care when she was in the Hospital in April and May 2020. Ms B needed a specific type of bowel care but did not receive it, as no skilled staff were available to provide it. Nurses did not update doctors that it had not been done.

Ms B then developed some new symptoms. These new symptoms may have meant that Ms B had a bowel blockage, but this was not considered. She was discharged from the Hospital on 5 May without being seen by a doctor and sadly died.

We could not be sure that the inadequate bowel care, or poor communication about this, contributed to Ms B's death, as she was very unwell with other problems. However, these failings meant that there was a loss of dignity for Ms B. We also identified that the Health Board should have considered Ms B and Mrs A's rights under the Human Rights Act – Article 8, the right to respect for private and family life. In our investigation, we also saw that record keeping fell short of the requirements expected for both doctors and nurses.

Concerningly, we saw similar failings in basic nursing care, in record keeping and in communication in previous cases we have investigated about this Hospital.

We acknowledged that Ms B was in hospital during the early days of the COVID-19 pandemic. Still, Ms B's care should have been better.

We were concerned that the Health Board did not respond to Mrs A's complaint well and robustly enough. Its first response did not identify everything that the Health Board did wrong. Its second response also did not fully acknowledge all the failings. Overall, we decided

that the Health Board did not review Ms B's care in a detailed, rigorous, open and transparent way. The way it handled the complaint put Mrs A to unnecessary additional time and trouble in pursuing her concerns, at a time of bereavement. This contributed to a lack of candour on the part of the Health Board.

To remedy the injustice to Mrs A, and ensure that lessons were learned, we recommended that the Health Board reviewed its complaint handling and responses, in light of the Duty of Candour.

Case example 3

Mr D's complaint (202205762)

Swansea Bay University Health Board

Mr D complained that he was not informed of his positive COVID-19 test when he was a patient at X Hospital. He also said that he was not given the right discharge advice about self-isolation.

Shortly after Mr D was discharged, his wife, Mrs A, caught COVID-19 and sadly died. We could not be sure how Mrs A caught COVID-19; we focussed only on whether the ward procedures which were in place at the time of Mr A's discharge were followed.

The Health Board acknowledged in its complaints response that there was no record of Mr D being given information in an appropriate discharge letter.

We were concerned that Swansea Bay University Health Board could not provide us with evidence to show that it told Mr D about the positive COVID-19 test or gave him information and advice about the self-isolation period, as it should have done, according to its ward policy at the time.

We recommended that the Health Board should apologise to Mr D and pay him £750 in recognition of these failings. The Health Board agreed to this as an alternative to our investigation.

However, although the Health Board accepted that it's records were incomplete and agreed to our recommendations, it took further detailed discussions (also with its legal department) before the full settlement, including the modest financial payment, was finally accepted.

Case example 4

Mrs H's complaint (202203723)

Aneurin Bevan University Health Board

We investigated Mrs H's complaint, on behalf of her brother (Mr J), that the Health Board had unreasonably delayed Mr J's treatment for colorectal cancer.

We found that, although the Health Board had informed Mr J on 1 February 2022 that he would have surgery on 21 March, it did not schedule the surgery, as it had indicated. Mr J only found this out when he contacted the ward the day before he was due to be admitted to hospital. The Health Board then took no action to resolve the matter until it was prompted to reschedule the surgery, after telephone calls and a complaint from Mr J's family.

This resulted in an avoidable 5-week delay until the surgery took place. The overall time between suspected cancer referral to the start of the treatment was outside the National Pathway guidelines for colorectal cancer. This caused injustice to Mr J. For him to find out the day before that the surgery he was expecting to take place, and for which he had prepared, was not in fact going ahead, must have been devastating, particularly as it turned out that this was due to an error by the Health Board in not booking the surgery in the first place.

Although the records clearly indicated that the Health Board made a mistake, its complaint response to Mr J was not candid and was contrary to the Putting

Things Right (PTR) scheme, which places a "duty to be open" on the Health Board.

It was only in response to our investigation that the Health Board acknowledged that the surgery had not been booked. It should have been open with Mr J abut this from the start, when it responded to his complaint.

The Health Board agreed to our recommendation that it should apologise for the failings and complete an audit of its colorectal scheduling processes and controls.

Case example 5

Mrs V's complaint (202006310)

Cwm Taf University Health Board

Mrs V complained to us about the care and treatment provided to her cousin, Ms F, by Cwm Taf Morgannwg University Health Board.

We found that the Health Board missed opportunities to identify and treat the appendicitis that caused Ms F's ruptured appendix. When Ms F attended the Ambulatory Emergency Surgical Unit at Princess of Wales Hospital on 17 July, appendicitis was not suspected, despite symptoms including severe abdominal pain, unusually low blood pressure and blood test results which indicated the presence of a significant infection. Instead of being admitted to hospital, Ms F was sent home without being prescribed antibiotics and without the Health Board arranging appropriate and timely investigations, including scans.

When Ms F returned for a review and further investigations on 20 July, the scan ruled out gallstones as the cause of her symptoms, but again she was not admitted to hospital, and told to return 2 days later.

Sadly, Ms F did not return for further review, and she died at home on 1 August 2020.

We found that, on the balance of probabilities, if the Health Board had provided appropriate care on 17 or 20 July, Ms F's appendicitis would have been identified and treated and her

death would have been avoided.

Although we found serious failings in this case, we were concerned that the Health Board's own investigation into Ms V's complaint did not find that it had done anything wrong, despite the case being discussed "at length" at a Surgical Clinical Governance meeting. On the contrary, the view at the meeting was that Ms F had received," ...the standard treatment, as the other surgeons would have provided...". In our view, the Health Board missed clear opportunities during the complaints response process to identify failings at an earlier stage and avoid the need for Ms F's family to escalate their complaint to us. However, when we shared the draft version of our report and our clinical advice with the Health Board, it accepted our recommendations.

We recommended that the Health Board should apologise and provide legal support to secure appropriate financial redress for Ms F's family. We also recommended that our findings should be reviewed by the Surgical Clinical Governance Team. The Health Board agreed to comply with our recommendations.

Case example 6

Miss X's complaint (202102028)

Cardiff & Vale University Health Board

Miss X complained about the care and treatment her late father, Mr Y, received at Cardiff and Vale University Hospital of Wales ("the Hospital") in March 2020.

He went to the Emergency Department ("the ED") but was sent home. Two days later, he was admitted to the Hospital but sadly died a few days later, after emergency surgery.

We found that Mr Y should not have been discharged from the ED as he was, because his clinical history had not been assessed. Also, the Health Board did not take enough information about Mr Y's bladder symptoms, constipation and new large groin lump. These symptoms pointed to an obstructed hernia which needed treatment, but Mr Y was discharged without adequate assessment. If the

Health Board assessed and admitted him at the time, the outcome for him might have been different.

Mr Y was admitted to the Hospital 2 days later. We found that his symptoms were again not promptly examined and recognised. This led to a delay before Mr Y underwent surgery, which meant that his condition worsened. When a delayed scan led to the diagnosis of a strangulated hernia, Mr Y needed emergency surgery.

Mr Y was very ill following surgery, but we found that he was not moved to the Intensive Care Unit ("ICU"), as it was determined that he would not benefit from this. We found that this decision reduced his chances of survival. Had the clinical failings not occurred, and had Mr Y received ICU care following surgery, his deterioration and death might have been prevented.

We acknowledged that the COVID-19 pandemic was beginning at the time Mr Y was admitted. This was creating extreme pressure for the Hospital staff. Even so, Mr Y was an emergency case and he did not receive the appropriate standard of care.

We made several recommendations, which the Health Board accepted, including an apology and carrying out a case review to discuss assessment and diagnosis of strangulated hernias.

The Health Board's response to the original complaint accepted that communication with Mr Y's family was poor. However, we were concerned that its investigation did not identify that there were several missed opportunities to treat Mr Y and that there were therefore failings in the care provided to him.

The Health Board could have identified actions to remedy these failings sooner. Instead, the family had to pursue their complaint through our office, costing them additional time and causing more distress. Overall, we questioned the robustness of the Health Board's investigation.

Appendix 2

Duty of Candour and Quality

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 includes the Duties of Candour and Quality, provisions in the Act aim to:

- strengthen the existing Duty of Quality on NHS bodies and extend this to the Welsh Ministers in relation to their health service functions.

- establish an organisational Duty of Candour on providers of NHS services, requiring them to be open and honest with patients and service users when things go wrong.

The Act:

- places an overarching Duty of Quality on the Welsh Ministers; and

- reframes and broadens the existing Duty on NHS bodies.

The Duty seeks to strengthen governance arrangements by requiring the Welsh Ministers and NHS bodies to report annually on the steps they have taken to comply with the Duty and assess the extent of any improvement in outcomes.

The Act also places a Duty of Candour on providers of NHS services (NHS bodies and primary care) - supporting existing professional duties.

The Duty requires NHS providers to follow a process –set out in Regulations – when a service user suffers an adverse outcome which has or could result in unexpected or unintended harm that is more than minimal and the provision of health care was or may have been a factor. There is no element of fault, enabling a focus on learning and improvement, not blame.

Welsh Ministers have issued statutory guidance in relation to the Duty of Candour.

The Duty seeks to promote a culture of openness and improves the quality of care within the health service by encouraging organisational learning, avoiding future incidents.

The Act requires NHS providers to report annually about when the Duty has come into effect - how often the Duty has been triggered, a description of the circumstances leading to the event and the steps taken by the provider with view to preventing any further occurrence.

NHS Complaints Process

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 came into force in April 2011. They prescribe arrangements for complaint handling in all NHS bodies in Wales and were supplemented by guidance entitled "Putting Things Right". Complaints must be investigated properly and appropriately and details of complaints should be shared with the staff member involved "where appropriate". A complainant should generally receive a response within 30 working days; if this is not possible, the response should be sent within six months and the complainant kept informed of the delay and the reason for it. Lessons should be learned from complaints and complainants informed of action which has been taken as a result of the complaint.

An NHS body must investigate matters raised in a concern in the manner which appears to the body to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently, having particular regard to the matters listed in Regulation 23 of the Regulations, including whether the person investigating the matters raised required independent medical or other advice.

The Regulations contain provision for the payment of redress in certain circumstances if the investigation concludes that harm may have been caused to the complainant through the fault of the organisation. Further investigation may be necessary if the initial investigation concludes that this may be the case and extended timescales apply to the consideration of redress.

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