



Pwyllgor Ansawdd, Diogelwch a Phrofiad/ Quality, Safety and Experience Committee

DYDDIAD Y CYFARFOD / DATE OF MEETING:	08 OCTOBER 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Policy 894: Listening to People - Integrated Patient Safety, Concerns Management and Resolution Policy
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Louise O'Connor, Assistant Director of Legal Services and Patient Experience

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/ For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The Committee is asked to approve Policy 894, Listening to People: Integrated Patient Safety, Concerns Management and Resolution Policy, for implementation across Hywel Dda University Health Board (the Health Board). The policy has been developed in accordance with the Health Board's Written Control Documentation requirements and provides the strategic framework for transition from Putting Things Right to the national Listening to People arrangements introduced from 1 April 2026.

The policy establishes a single, integrated and person-centred approach to concerns, complaints, patient safety incidents, claims, redress and wider quality intelligence. It positions listening, learning and improvement as core organisational responsibilities and supports the Health Board's duties of quality, candour, openness and continuous improvement.

Cefndir / Background

Listening to People represents a significant change in how NHS organisations in Wales respond to concerns. It strengthens the emphasis on early and compassionate engagement, accessible communication, proportionate review, timely resolution, learning and demonstrable improvement.

Policy 894 brings previously connected but sometimes separately managed routes into one strategic framework. This includes complaints, incidents, claims, redress and patient experience feedback, together with interfaces such as safeguarding, Medical Examiner concerns, mortality review, inquests, Prevention of Future Death reports, Ombudsman matters and external scrutiny.

The policy reflects the National Patient Safety Plan's Quality Management System approach by bringing together quality planning, control, assurance and improvement. It also aligns the Health Board's arrangements with the Listening to People statutory framework, the NHS

concerns and redress regulations, the Duty of Quality, the Duty of Candour and Public Services Ombudsman for Wales complaint-handling principles.

The policy has been informed by consultation through the Listening and Learning Sub-Committee and the Health Board's staff and trade union consultation process.

Asesiad / Assessment

The policy provides a clear strategic foundation for an integrated patient safety and concerns management system. Its central features are:

- a single integrated triage approach, so concerns are assessed consistently regardless of how they enter the organisation;
- proportionate decision-making based on harm, risk, complexity, safeguarding, potential qualifying liability and learning potential;
- an expectation of early resolution where appropriate, supported by a mandatory offer of a Listening Discussion;
- coordinated review through the principle of 'Investigate Once, Investigate Well', reducing duplication and the burden on patients, families and staff;
- multidisciplinary oversight of complex, high-risk or significant concerns through Concern Management Groups;
- clear accountability for Clinical Care Groups and services to investigate, implement actions, evidence delivery and evaluate impact; and
- stronger organisational learning, with themes and actions triangulated across complaints, incidents, claims, patient feedback, safeguarding, legal and other quality intelligence.

The policy supports a Just Culture and psychological safety, recognising the importance of compassionate support for staff as well as patients and families. It also strengthens expectations concerning accessibility, reasonable adjustments, advocacy, equality monitoring and the identification of potential inequity or discrimination.

The principal strategic risk is not the policy itself, but inconsistent implementation. This could result in fragmented pathways, duplicated investigations, missed safeguarding, candour or redress considerations, variable investigation quality, delayed responses and insufficient evidence that learning has improved care. These risks will be mitigated through supporting procedures, integrated triage, role-specific training and competence arrangements, clear governance and escalation, performance reporting and monitoring of the implementation and impact of improvement actions.

Assurance will be provided through the Listening and Learning Sub-Committee, with escalation and assurance reporting to the Quality, Safety and Experience Committee and, where appropriate, the Board. The primary measure of success will be the extent to which concerns lead to measurable learning, improvement and reduced risk of future harm, rather than compliance with timescales alone.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to approve Policy 894 for implementation across the Health Board.

Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.22 Approve policies and plans within the scope of the Committee, having taken an assurance that the quality and safety of patient care has been considered within these policies and plans.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	No specific Datix risk is cited in this report. Implementation risks will be monitored and escalated through established quality and safety governance arrangements.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	All applicable: Safe; Timely; Effective; Efficient; Equitable; Person-centred.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Striving teams 3. Great care
Nodau Cynllunio 2026/27 Planning Goals 2026/27	2. Customer Service Excellence 1. Healthy, Thriving Teams 6. Safe, Timely, High Quality Care 5. People First, Digital Always Choose an item.
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	7. Improve health and well-being by focusing on prevention and early intervention, while working in partnership to ensure everyone has equal access to care and opportunities for good health
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (complete for strategic change and/or significant service changes)	6. A culture of testing and learning will be encouraged, enabled, supported and celebrated.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	NHS (Concerns, Complaints and Redress) Arrangements (Wales) Regulations 2011, subsequent amendments – Listening to People Process 2026 Quality and Engagement Act
Rhestr Termau: Glossary of Terms:	Contained in body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Listening and Learning Sub-Committee Global Staff and TU consultation process

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct financial approval is sought through this report. Implementation will require coordinated operational capacity, training, investigation capability, digital and performance support, and sustained leadership oversight within existing planning and governance arrangements. Any material resource pressures identified through implementation should be escalated through the appropriate planning route.
Ansawdd / Gofal Claf: Quality / Patient Care:	Positive strategic impact. The policy is intended to improve early engagement, accessibility, proportionality, coordination, investigation quality, organisational learning and evidence that concerns lead to safer care and better patient experience.
Gweithlu: Workforce:	All staff have responsibilities to listen, act, report, escalate and contribute to learning. Clinical Care Groups and services must ensure staff capacity, competence and oversight for early resolution, investigation and improvement. The policy promotes Just Culture, psychological safety and compassionate support for staff involved in concerns.
Tegwch Iechyd: Health Equity:	The policy strengthens requirements for accessible communication, reasonable adjustments, advocacy, language support and equality monitoring. It requires analysis of barriers, disparities, discrimination-related concerns and differential outcomes to inform improvement action. An updated Equality Impact Assessment is attached.
Risg: Risk:	Key risks relate to inconsistent implementation, fragmented pathways, delayed or duplicated investigations, missed statutory considerations, variable investigation quality, insufficient workforce capability and failure to demonstrate learning impact. Mitigations include integrated triage, Concern Management Groups, defined accountabilities, training

	and competence arrangements, action tracking, performance reporting and committee escalation.
Cyfreithiol: Legal:	The policy supports compliance with the NHS concerns and redress regulations as amended for Listening to People, the Duty of Quality, the Duty of Candour, safeguarding duties, Public Services Ombudsman for Wales complaint-handling standards and associated statutory guidance. Safeguarding requirements take precedence where applicable.
Enw Da: Reputational:	Effective implementation should strengthen transparency, trust and public confidence. Inconsistent, delayed or inaccessible handling of concerns, or failure to evidence learning, would create reputational and regulatory risk.
Gyfrinachedd: Privacy:	Information must be managed through approved Health Board systems and communication channels, with appropriate recording, access and information-governance controls. Detailed operational requirements will be set out in supporting procedures.
Cydraddoldeb: Equality:	Updated Equality Impact Assessment attached. The policy includes explicit requirements concerning accessibility, inclusion, reasonable adjustments, advocacy, equality monitoring and action on identified disparities or discrimination.

‘Listening to People’ Integrated Patient Safety, Concerns Management and Resolution Policy

Policy information

Policy number: 1561

Classification: Corporate

Supersedes: 514/894

Version number: 1

Date of Equality Impact Assessment: ***

Approval information

Approved by: QSEC

Date of approval:

Date made active:

Review date:

Summary of document:

This policy replaces the previous Putting Things Right approach with an integrated Listening to People framework. It brings together concerns, complaints, patient safety incidents, claims and redress, alongside related interfaces such as Medical Examiner cases, inquests, safeguarding referrals and external reviews, within a unified patient safety and learning system.

The purpose is to establish a single integrated framework for listening, responding, resolving, learning and improving from concerns, patient safety events and feedback.

The National Patient Safety Plan for NHS Wales 2026–2031 places Quality Management Systems (QMS) at the centre of patient safety improvement, bringing together quality planning, quality control, quality assurance and quality improvement into a single, coherent framework. The Health Board's Integrated Patient Safety Triage Model reflects this approach by ensuring that complaints, incidents, claims, redress cases, patient experience feedback, safeguarding concerns and other quality intelligence are considered together, enabling a proportionate, learning-focused response and supporting continuous improvement in the quality and safety of care.

This policy is also compliant with the Public Services Ombudsman for Wales Act (2019) and the Complaints Standards Authority Principles for Complaint Handling; and the Health and Social Care (Quality and Engagement) (Wales) Act (2020).

This policy incorporates the all Wales Listening to People, NHS Wales Complaints, Incidents and Redress Process – Guidance for organisations 2026 [Hywel Dda Patient Experience - LTP - Organisational Guidance.pdf - All Documents](#) (opens in a new tab)

Scope:

This policy applies to all staff who have a responsibility to report, manage and / or formally review concerns or be engaged in the formal review of a concern.

The Policy covers concerns about:

- Health Board services;
- Services provided by Health Board employed staff; and
- Services provided by the independent or voluntary sector which are funded by the Health Board.

The Health Board expects its independent contractors to have processes in place that meet the requirements of the Listening to People Regulations and the Duty of Candour requirements and this should be clearly specified within any contractual documentation and agreements.

To be read in conjunction with:

Accessible Communication and Information Standards in Healthcare (Welsh Government, 2025): [view the standards](#)

[982 – Incident, near Miss and hazard Reporting Policy](#) – opens in a new tab

[429 - Management and Distribution of Safety Alerts and Notices](#) Policy – opens in a new tab

[004 - Claims Management Policy](#) – opens in new tab

[018 - Staff Attending Inquests / Court and Assisting with Police Investigations Guideline](#) – opens in new tab

[558 - Management of Nursing and Midwifery Medication Errors / Near Misses Policy](#) – opens in new tab

All national and local guidance documents – found at : [Hywel Dda Quality, Assurance and Safety - Home](#) (intranet site containing information on concerns management, guidance and training materials and the learning library).

Listening to People Standard Operating Procedures and Clinical Care Group supporting guidance are available through the relevant Health Board intranet pages.

Patient information:

[Patient support services \(complaints & feedback\) - Hywel Dda University Health Board](#) (website page) – opens in new tab

Owning group:

Nursing, Quality and Patient Experience Directorate
Listening and Learning Sub Committee

Executive Director job title: Director of Nursing, Quality and Patient Experience

Reviews and updates:

1.0 – New Policy superseding 894 Putting things right policy PTR - Management and Resolution of Concerns Policy

Keywords

Listening to People, Incident, Complaint, Claim, Concern, Duty of Candour, Being Open, Investigation, patient safety, experience and feedback, accessible communication, equality, discrimination and reasonable adjustments.

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Introduction

Listening is everyone's responsibility. Learning is everyone's responsibility. Improving is everyone's responsibility.

By creating a culture of compassion, openness, psychological safety and continuous learning, Hywel Dda University Health Board is committed to ensuring that every concern contributes to safer care, better experiences and improved outcomes for the people and communities we serve.

The true measure of effectiveness is not how efficiently concerns are processed, but how successfully they are used to improve quality, reduce avoidable harm, enhance patient experience and strengthen public trust in our services.

Providing safe, effective and person-centred care is a fundamental responsibility of NHS Wales. Despite significant advances in healthcare, patient harm remains a recognised challenge internationally. The World Health Organisation (WHO) continues to report that around one in ten patients experience harm during healthcare, with more than half of such harm considered preventable. Patient safety incidents occur across all healthcare settings, including hospitals, community services, primary care and mental health services. Common sources of avoidable harm include diagnostic error, delays in treatment, communication failures, inaccessible information, medication-related harm, healthcare-associated infections and failures in care coordination. [\[who.int\]](#)[\[who.int\]](#)

The WHO Global Patient Safety Report 2024 highlights that improving patient safety requires strong organisational cultures, effective incident reporting and learning systems, patient and family engagement, compassionate communication, and the continuous use of information to identify risks and prevent recurrence. Importantly, the report emphasises that listening to patients, families and staff is essential to creating safer systems of care. [\[who.int\]](#).

In Wales, the introduction of Listening to People from 1 April 2026 represents a significant evolution in the way NHS organisations respond to concerns, complaints, incidents and redress. Listening to People replaces the previous Putting Things Right arrangements and reflects a strengthened national commitment to openness, compassion, early resolution, learning and improvement. The framework is designed to ensure that every person who raises a concern is treated with dignity, fairness, respect and compassion, whilst ensuring organisations learn effectively from feedback, concerns and adverse events. [\[New Listen...o concerns | SharePoint\]](#), [\[01.-FINAL-...I-Guidance | PDF\]](#)

The principles underpinning Listening to People are to:

- Enhance and improve safer care delivery through listening and acting;
- Promote an open and just culture;
- Increase transparency and trust;
- Mitigate against future harm;
- Support staff development and learning; and
- Meet legal duties and ethical standards.

Accordingly, the Health Board has a responsibility to maintain systematic arrangements that safeguard patients, service users, staff, visitors, NHS resources and organisational reputation. This responsibility extends beyond identifying what happened when concerns arise; it requires a commitment to understanding why events occurred, examining contributory factors, listening to the experiences of those affected, and implementing meaningful actions that reduce the risk of recurrence.

An integrated approach to incidents, complaints, claims, patient safety events, safeguarding concerns and feedback enables the organisation to identify themes, learn across traditional organisational boundaries and strengthen the quality and safety of services.

The focus of all concern management activity should therefore be on improvement, proportionality, transparency, accountability and organisational learning.

This policy incorporates the arrangements required for the management of concerns in accordance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, as amended by the Listening to People statutory framework and associated guidance introduced on 1 April 2026.

These arrangements establish a consistent approach to managing concerns across NHS Wales, including requirements relating to listening discussions, early resolution, investigations, redress, duty of candour, learning and service improvement. [\[gov.wales\]](https://gov.wales), (opens in a new tab).

Where concerns identify actual or potential risks to children or adults at risk, these will be managed in accordance with safeguarding legislation and procedures, including the duty to report under the Social Services and Well-being (Wales) Act 2014.

Safeguarding concerns are not managed primarily through Listening to People. Where information received through a concern, complaint, incident, Medical Examiner communication or other route indicates actual or suspected abuse, neglect, exploitation, deliberate harm or risk to a child or adult at risk, the All-Wales Safeguarding Procedures and relevant Health Board safeguarding policies take precedence. The Listening to People process must not delay or interfere with immediate safeguarding action, statutory reporting, strategy discussions, enquiries, police involvement or multi-agency protection arrangements.

In some circumstances, the presence of safeguarding concerns may mean that the issues raised are not suitable for the Listening to People process, either in whole or in part. Decisions about whether Listening to People activity can proceed, should be paused, adapted or undertaken in parallel must be made in consultation with safeguarding leads and clearly documented.

The Health Board is also required to comply with the Public Services Ombudsman (Wales) Act 2019, which established the Complaints Standards Authority (CSA) for Wales. The CSA requires public bodies to ensure complaint handling arrangements are:

- Complainant Focused
- Simple
- Fair and Objective
- Timely and Effective
- Accountable
- Committed to Continuous Improvement. [\[ombudsman.wales\]](https://ombudsman.wales), (opens in a new tab).

These principles align closely with the values and expectations of Listening to People and with the Health Board's duties under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, including the Duty of Quality and Duty of Candour. Together they provide the framework through which

the organisation listens, learns and improves in response to concerns raised by patients, families, unpaid carers, staff and partners.

This policy and all associated procedures are designed to ensure that every concern is managed in a manner that is person-centred, proportionate, compassionate, transparent and focused on learning and improvement, so that the experiences of people who use our services lead to safer care and better outcomes for all.

Policy statement

At Hywel Dda University Health Board, listening, learning and improving are fundamental to the delivery of safe, effective and compassionate care. We are committed to creating a culture in which the voices of patients, families, unpaid carers, staff and partners are actively welcomed, valued and acted upon to improve experiences, outcomes and services.

We recognise that concerns – no matter how they are raised whether this be a complaint, an incident, an adverse event, a near miss, a claims, or a letter from the medical examiner – and compliments and feedback provide powerful opportunities to understand what matters most to people and to learn from both excellence and when things go wrong. We are committed to responding to concerns with empathy, kindness, openness and respect, ensuring that every individual is listened to, treated fairly and supported throughout the process.

Delivering safe, high-quality care and responding appropriately when concerns are raised is everyone's responsibility. Every member of staff, irrespective of role or profession, has a duty to listen, act, escalate concerns appropriately, support learning and contribute to continuous improvement. This responsibility extends to leaders at all levels, who must foster an environment in which people feel safe to speak up, ask questions, share experiences and report concerns without fear of blame, discrimination or reprisal.

The Health Board is committed to promoting a Just Culture that seeks to understand why events occur rather than simply identifying who was involved. We will approach concerns with professional curiosity, compassion and fairness, recognising that most errors arise from a combination of human, system, organisational and environmental factors. Investigations and reviews will therefore focus on understanding contributory factors, identifying opportunities for improvement and reducing the likelihood of future harm, whilst maintaining appropriate accountability where required.

We recognise that involvement in adverse events, complaints, investigations and claims can have a significant emotional and psychological impact on staff. We are committed to supporting the wellbeing of our workforce and ensuring that staff involved in concerns are treated with dignity, compassion and respect. We will promote psychological safety, encourage reflective practice and provide appropriate support so that staff feel able to contribute openly to learning and improvement processes.

Through the Listening to People framework, the Duty of Quality, the Duty of Candour and our wider quality and safety arrangements, we will ensure that concerns are managed in a timely, proportionate, transparent and person-centred manner.

We will actively demonstrate how learning from concerns leads to improvements in care, strengthens public confidence and contributes to safer services for the population we serve.

Above all, we are committed to creating a culture where every voice matters, every concern is an opportunity to learn, and every interaction is grounded in compassion, respect and a shared commitment to continuously improving the quality and safety of healthcare.

Scope

This policy applies to all staff who have a responsibility to identify, receive, report, acknowledge, triage, manage, investigate, review, respond to, learn from or provide assurance in relation to concerns. It applies regardless of how the concern enters the organisation, including concerns received directly by any member of staff by email, telephone, letter, online form, in person or through another communication method, and concerns raised directly by patients, families, unpaid carers or representatives; complaints; incidents; near misses; adverse events; staff-reported patient safety issues; Medical Examiner communications; mortality review findings; inquests; Prevention of Future Death reports; claims; redress considerations; safeguarding concerns; commissioned service concerns; independent contractor issues; Ombudsman matters; regulator feedback; external scrutiny; or other quality, safety, experience or governance intelligence.

The policy covers concerns relating to NHS-funded care, treatment, support, communication, access, experience, safety, quality, professional practice, systems, processes and outcomes where Hywel Dda University Health Board is the responsible body, provider or commissioner.

The Policy covers concerns about:

- Health Board services;
- Services provided by Health Board employed staff; and
- Services provided by the independent or voluntary sector which are funded by the Health Board.

The Health Board recognises that independent contractors are responsible bodies under the Listening to People arrangements where they provide NHS-funded care.

The Health Board expects independent contractors and commissioned providers to maintain processes that meet the requirements of the Listening to People Regulations, Duty of Candour and relevant contractual obligations.

Where a concern includes safeguarding issues, the All-Wales Safeguarding Procedures and relevant Health Board safeguarding policies take precedence over this policy. Such concerns must be referred and managed through the appropriate safeguarding pathway without delay. The Listening to People process must only proceed where it is appropriate and does not compromise safeguarding enquiries, statutory duties, police involvement or multi-agency protection arrangements.

Where a matter is excluded from, unsuitable for, or paused under Listening to People, the rationale must be recorded and the person raising the concern must be signposted to the appropriate process wherever this can be done safely and lawfully.

Aim

The aim of this policy is to establish a single, integrated and person-centred approach to the management of concerns, ensuring that patients, families, unpaid carers and staff are listened to, treated with compassion and respect, and supported throughout the process.

Through timely, proportionate and transparent review of concerns, the Health Board seeks to understand not only what happened, but why it happened, so that learning can be translated into

meaningful improvement, safer care, better experiences and improved outcomes for the people and communities we serve.

Objectives

This policy aims to:

- Promote a culture of openness, compassion, professionalism and continuous improvement, where feedback, concerns and adverse events are welcomed as opportunities to learn.
- Ensure compliance with the Listening to People framework, the Duty of Candour, the Duty of Quality and all relevant statutory and regulatory requirements.
- Create an environment of psychological safety in which patients, families, unpaid carers and staff feel confident to speak up, raise concerns, share experiences and contribute to learning without fear of blame or disadvantage.
- Ensure concerns are reviewed in a timely, proportionate and person-centred manner, with the level of review informed by risk, harm, complexity and learning potential.
- Support a Just Culture approach that seeks to understand human, organisational and system factors contributing to events, promoting learning and improvement rather than inappropriate blame.
- Use intelligence from concerns, incidents, complaints, claims, letters from the medical examiner, patient feedback and staff experiences to identify themes, reduce avoidable harm and drive service improvement.
- Ensure learning is translated into demonstrable improvements in patient safety, quality of care, patient experience and workforce wellbeing.
- Support staff involved in incidents, complaints, investigations and claims, recognising the importance of wellbeing, reflective practice and compassionate leadership.

Principles

The management of concerns within Hywel Dda University Health Board will be underpinned by the principles of compassion, openness, fairness, proportionality, transparency, inclusivity, learning and continuous improvement. The Health Board is committed to ensuring that every concern is managed in a way that reflects the values of Listening to People and recognises the needs of individuals raising concerns, those affected by concerns and staff involved in their review.

To achieve this, the Health Board will ensure that:

- Every concern is treated as an opportunity to listen, learn and improve.
- People who raise concerns are treated with dignity, empathy, respect and courtesy, and are actively involved in the process wherever possible.
- Concerns are acknowledged within five working days and managed promptly, openly and in accordance with statutory requirements and agreed timescales.
- Listening Discussions are offered at the earliest appropriate opportunity through the person's preferred and accessible communication method, to understand what matters most to those affected and the outcomes they hope to achieve.
- Reviews and investigations are proportionate to the level of harm, complexity, risk and learning potential presented by the concern.
- Reviews focus on understanding contributory factors, system influences and underlying causes rather than assigning blame, whilst maintaining accountability where appropriate.

- Patients, families, carers and staff are provided with accessible information, reasonable adjustments, advocacy and communication support where required.
- A named Health Board contact is identified to provide continuity, support and communication throughout the management of the concern. Staff must use approved Health Board communication channels and must not provide personal telephone numbers, personal email addresses or personal social media details. Subsequent or unrelated concerns must be redirected into the Health Board's published concerns arrangements and recorded appropriately.
- Staff involved in concerns, incidents, investigations and claims are treated fairly and supported appropriately to promote wellbeing, accessible communication, effective information sharing, reflective learning and psychological safety.
- Learning and improvement actions are identified, implemented, monitored, shared and evaluated to ensure meaningful and sustainable change.
- Information from concerns is triangulated with patient safety, quality, safeguarding, workforce and legal intelligence to support organisational learning and system-wide improvement.
- Consideration is given to the offer of redress, in accordance with the Regulations, where review of the facts identifies a qualifying liability in tort.
- All concerns are managed in accordance with the Listening to People Regulations, the Public Services Ombudsman for Wales Complaint Handling Standards and relevant Welsh Government guidance.

Definitions

Concern

A concern is any expression of dissatisfaction, worry or issue raised about NHS-funded care, treatment or services, or any patient safety incident, near miss, adverse event or other matter that indicates actual or potential harm, poor experience, service failure, risk, unresolved dissatisfaction or an opportunity for learning and improvement. A concern may be raised by a patient, family member, carer, representative, member of staff, partner organisation, Medical Examiner, coroner, regulator, commissioner, independent contractor or other route. Concerns must be triaged and managed through the most appropriate pathway, including Listening to People, patient safety incident management, safeguarding, Duty of Candour, redress, claims, inquest, mortality review, external scrutiny or other governance arrangements.

Enquiry

A request for information, clarification, assistance, signposting or resolution of a simple issue that does not require the formal Listening to People process and where there is no allegation of service failure, harm or unresolved dissatisfaction. It is generally managed through routine service response or patient support functions.

Acknowledgement

A formal written confirmation issued by the responsible body not later than 5 working days after it receives notification of a concern, including the offer of a Listening Discussion and communication support information. The acknowledgement may be made in writing or electronically, depending upon how the concern was notified. Where a concern was notified verbally, the acknowledgement must be in writing.

Stage 1 – Early Resolution

Stage 1, also described as “Listen and Act”, is a rapid and proportionate process for resolving straightforward concerns within 10 working days from acknowledgement. It should involve listening, discussion, explanation, apology and immediate action where appropriate, with the aim of resolving the concern without the need for a formal investigation or written response. The receiving service or Clinical Care Group is responsible for undertaking Stage 1, supported by the Patient Support Team where required. An accountable lead and named contact must be identified. Where the concern cannot be resolved within Stage 1, is not suitable for early resolution, indicates actual or potential harm, raises Duty of Candour, safeguarding or redress considerations, involves disputed facts or significant learning, or the person remains dissatisfied, it must be escalated promptly for integrated triage and consideration under Stage 2. The escalation decision and rationale must be recorded and communicated.

Stage 2 – Complaint / Formal Investigation

Stage 2, also described as “Investigate, Respond and Learn”, is the formal investigation stage for concerns that are unsuitable for early resolution or where early resolution has been unsuccessful.

Stage 2 applies where the issues are more complex, involve actual or potential harm, significant service failure, disputed facts, unresolved dissatisfaction, safeguarding considerations, Duty of Candour issues, qualifying liability considerations or significant learning opportunities. The investigation will culminate in a formal written outcome and learning response, communicated in the manner agreed with the person raising the concern wherever possible.

Listening Discussion

A mandatory offer, made at the point of acknowledgement, of an in-person discussion, which may take place by telephone, video or face-to-face conversation, to understand the concern, communication needs, desired outcomes and suitability for early resolution.

Patient Safety Incident

A patient safety incident is an unintended or unexpected incident that could have or did lead to harm for one or more patients or service users receiving NHS-funded healthcare. Note: the term “patient safety incident” refers to an incident occurring during the delivery of healthcare. It is recognised that this may not always be to a patient but can also affect other service users in receipt of NHS-funded healthcare. The language throughout this document has been updated where possible to reflect this but for the avoidance of doubt, the definition of a patient safety incident applies equally to a service user in receipt of NHS funded healthcare even if they are not classified as a patient (NHS Executive 2023).

Never Events

The current never event list can be found on the attached link:

du.nhs.wales/files/incidents/supporting-section-1-never-events-list-pdf/ - opens in new tab

Occurrence of a never event, triggers the Management of Patient Safety Incidents and Serious Concerns Procedure. Advice can be sought from the Quality, Assurance and Safety Team, if there is any doubt as to whether an incident is a never event.

Adverse Event

Any event that has given or may give rise to actual or possible personal injury, patient dissatisfaction, or to property loss or damage.

Near Miss

Any event or omission that could have potentially caused harm, but due to prompt action by a member of staff, or simply because of good fortune was prevented.

Qualifying Liability (QL)

Where there is proven personal injury or loss arising out of, or in connection with, the care or treatment of a patient due to the service provided by the responsible body.

Redress

Redress relates to situations where a patient may have been harmed and that harm was caused by NHS care. It may include:

- A written apology;
- An explanation;
- A report detailing actions taken to prevent recurrence;
- Financial compensation and/or remedial treatment, subject to the requirements of the Regulations.

Where redress is being considered or a claim for compensation made the Health Board's Policy for Claims Management will be followed.

Vexatious or Frivolous Concern

A concern that may be excluded under the Regulations where it is deemed vexatious or frivolous. Any decision to apply this provision must be exceptional, justified, recorded, proportionate and communicated clearly to the person raising the concern.

Safeguarding Concern

A concern indicating actual, suspected or potential abuse, neglect, exploitation, deliberate harm, ongoing risk or risk to a child or adult at risk. Safeguarding concerns must be managed in accordance with the All Wales Safeguarding Procedures and relevant Health Board safeguarding policies. Safeguarding requirements take precedence over the Listening to People process. Where a concern raises safeguarding issues, it must be referred immediately through the appropriate safeguarding pathway and may not be suitable for management under Listening to People, or may require the Listening to People process to be paused, adapted or progressed only where this does not compromise safeguarding enquiries, statutory duties, police involvement or multi-agency protection arrangements.

Public Services Ombudsman for Wales (PSOW)

The independent organisation that can review complaints about public services in Wales, including the NHS, where an individual remains dissatisfied following the NHS investigation.

Medical Examiner Service

A statutory service providing independent scrutiny of deaths prior to registration and which interfaces with Listening to People processes via specific communication duties

Llais

The independent citizen voice body in Wales that provides free advocacy and support to people using health and social care services.

Advocacy

Independent support offered to people raising concerns; must be actively offered during the Listening Discussion

Integrated Patient Safety Triage

The process used to assess, prioritise and determine the most appropriate management pathway for concerns, incidents, complaints, claims and feedback.

Concern Management Group (CMG)

A multidisciplinary forum established to oversee and coordinate the management of complex, high-risk or significant concerns.

Learning Review

A structured review undertaken to understand what happened, why it happened and what can be learned to improve future care and services.

Formal Investigation

A proportionate investigation undertaken where concerns require detailed review, analysis and formal response.

Systems-Based Investigation

An approach that examines the wider systems, processes, environments and human factors that contribute to an event rather than focusing solely on individuals.

Just Culture

An approach that promotes openness, fairness and learning by balancing accountability with understanding of human and system factors.

Psychological Safety

An environment where people feel able to speak up, ask questions, report concerns and contribute to learning without fear of blame, punishment or negative consequences.

Professional Curiosity

The willingness to explore, question and understand circumstances fully rather than accepting information at face value.

Human Factors

The environmental, organisational and individual factors that influence human performance, safety and outcomes.

Patient Safety Event

Any unintended or unexpected event that resulted in, or could have resulted in, harm to a patient.

Patient Experience Feedback

Information provided by patients, families or carers regarding their experiences of care and services, including compliments, concerns and suggestions for improvement.

Primary considerations of practice

The Listening to People framework is founded upon the principles of accessibility, compassion, openness, proportionality, learning and continuous improvement. Every concern should be managed in a manner that ensures people feel heard, respected and supported, while enabling the Health Board to learn and improve from their experiences.

Who Can Raise a Concern

A concern may be raised by a patient or service user, a person affected by the actions or decisions of a responsible body, a member of staff, a representative acting on behalf of another individual, or a representative acting on behalf of someone who has died. The Health Board will seek to ensure that individuals are supported to raise concerns and will consider the suitability of representatives where appropriate.

Accessible Ways of Raising a Concern

The Health Board is committed to ensuring concerns can be raised in a way that is accessible and convenient for individuals. Concerns may be raised verbally, in writing or electronically and can be made through the Health Board's published concerns arrangements, available via its website and other communication channels. [Patient support services \(complaints & feedback\) - Hywel Dda University Health Board](#) (opens in a new tab).

Individuals will be offered reasonable adjustments, language support and advocacy where required to ensure equitable access to the concerns process. Concerns may be raised with any member of staff, who has responsibility for ensuring the concern is directed into the appropriate process.

Barriers to Raising Concerns

The Health Board recognises that some individuals and communities may experience additional barriers to raising concerns due to disability, language, culture, literacy, socio-economic circumstances, digital exclusion or concerns about discrimination. Staff must take proactive steps to reduce these barriers, identify and record communication and information needs, make reasonable adjustments, offer advocacy and language support, and support equitable access to the concerns process.

Concerns received directly by staff

Where a concern is received directly by a member of staff, including by email, telephone, text, letter or in person, the member of staff must listen respectfully, address any immediate safety or safeguarding issue and ensure the concern is recorded and directed into the appropriate Health Board pathway. Staff should use approved organisational contact details and systems. If an individual later raises a new or unrelated concern with a staff member who previously supported them, the concern should be acknowledged and redirected through the published concerns arrangements so that it can be recorded, triaged and managed consistently. Staff should seek managerial or Patient Support Team advice where boundaries, communication arrangements or staff wellbeing may be affected.

Acknowledgement and Early Engagement

All concerns will be acknowledged within five working days of receipt. As part of the acknowledgement process, individuals will be advised of the support available to them, including advocacy services, opportunities for a listening meeting, and will receive information about the next steps in managing their concern.

Right to a Listening Discussion

Every person raising a concern will be offered a Listening Discussion. This provides an opportunity to explain their concerns, discuss the impact on them, identify the outcomes they hope to achieve and determine the most appropriate approach to resolution. Listening Discussions may take place face-to-face, by telephone or virtually and are intended to support understanding, compassion, early resolution and person-centred decision making.

The Importance of Listening Discussions

The Listening Discussion is a foundational element of the Health Board's approach to concerns management and represents the first and most important opportunity to understand a person's experience, address their concerns and identify opportunities for early resolution. It is not simply a procedural requirement, but a person-centred conversation designed to ensure that individuals feel heard, respected and supported.

Listening Discussions provide an opportunity to understand the impact that events have had on patients, families, unpaid carers and staff, explore what matters most to them and agree realistic expectations regarding what can be achieved through the concerns process. They support openness, trust, compassion and shared understanding and help ensure that the Health Board responds to concerns in a manner that reflects individual needs, preferences and desired outcomes.

The Health Board expects Listening Discussions to be undertaken using active listening, compassionate communication and trauma-informed principles. Individuals should be provided with sufficient time to explain their experience, access appropriate advocacy or support where required, and receive clear information about the options available to them.

Listening Discussions also support the Health Board's objectives of preventing future harm, promoting early resolution, improving experiences and reducing the need for formal investigation where appropriate. Evidence indicates that meaningful early engagement improves satisfaction, strengthens relationships, supports learning and reduces escalation to more formal stages of the process.

The quality of a Listening Discussion may influence trust in the organisation more than the eventual outcome of the concern itself.

Matters Excluded from the Concerns Process

Certain matters fall outside the scope of the Listening to People arrangements. These include matters already investigated by the Public Services Ombudsman for Wales, Freedom of Information requests, staff employment matters, safeguarding matters, concerns that are subject to civil proceedings, duplicate concerns, concerns deemed vexatious or frivolous, Individual Patient Funding Request decisions and concerns raised outside the applicable time limits, unless exceptional circumstances apply. Where concerns fall outside the Regulations, individuals will be advised of the reason and directed to the most appropriate process where possible.

Enquiries will not be managed in accordance with this policy and individuals will be appropriately supported to the correct teams to ensure timely information and support is provided.

Proportionate and Risk-Based Approach

The Health Board will apply a proportionate approach to the management of concerns. The level of review or investigation undertaken will be informed by the nature of the concern, actual or potential harm, complexity, risk, safeguarding considerations, learning potential and any requirement to consider

qualifying liability. Not all concerns require the same level of review, and the approach taken should be thorough, timely and appropriate to the circumstances.

Level of Harm Grading Framework

The new Listening to People Organisational Guidance adopts a 5-level harm grading framework aligned to the NHS Wales Patient Safety Incident Reporting and Management Framework and Duty of Candour guidance. The framework is intended to support proportionality, escalation, investigation and consideration of Duty of Candour and Redress.

Harm Grade	Description	Examples
Grade 1 – No Harm	An event occurred but resulted in no harm to the patient.	Delay without clinical impact; fall with no injury; administrative error corrected before affecting care.
Grade 2 – Low Harm	Minor temporary harm requiring minimal intervention or resulting in limited impact.	Minor treatment delays; short increase in length of stay (1–3 days); minor injury requiring simple treatment.
Grade 3 – Moderate Harm	Harm requiring clinical intervention, additional treatment or escalation of care.	Avoidable injury requiring intervention; readmission; return to theatre; transfer to higher acuity care; RIDDOR-reportable incident.
Grade 4 – Severe Harm	Significant permanent harm, disability or major loss of function.	Permanent harm or disability; extended hospital stay (>15 days) with permanent sequelae; significant breach of national standards.
Grade 5 – Death	Death where healthcare may have contributed or where significant failures in care are identified.	Avoidable death or care contributing to death; maternal, perinatal or infant death; gross failure to meet standards; irreversible health effects resulting in death.

Application of Harm Grading

The Health Board will utilise the NHS Wales Harm Grading Framework to support the initial assessment and ongoing review of concerns. Harm grading assists in determining the most appropriate and proportionate response, including escalation requirements, safeguarding actions, Duty of Candour considerations, investigation methodology, governance oversight and assessment of potential qualifying liability. Harm assessments will remain dynamic throughout the management of a concern and may be revised as additional information becomes available.

Integrated Management of Concerns

The Integrated Patient Safety Triage Model ([appendix 1](#)) provides a single, coordinated approach to the assessment, management and oversight of concerns raised about care, treatment and services provided or commissioned by Hywel Dda University Health Board.

The model brings together concerns, complaints, incidents, claims, patient experience feedback, safeguarding concerns, Duty of Candour notifications, inquests, Prevention of Future Death reports and other sources of quality intelligence into a single process for assessment, review, investigation and learning. This approach supports the Listening to People requirement for an integrated system of concern management that is person-centred, proportionate, responsive and focused on learning and improvement.

The Integrated Patient Safety Triage Model will:

- Place patients, families, unpaid carers and staff at the centre of decision making.
- Ensure concerns are assessed consistently regardless of how they enter the organisation.
- Apply a proportionate response based upon harm, risk, complexity and learning potential.
- Promote early resolution wherever appropriate.
- Support timely identification of Duty of Candour, safeguarding, legal and patient safety requirements.
- Ensure learning is shared across services and organisational boundaries.
- Facilitate a single investigation wherever possible ("Investigate Once, Investigate Well").
- Support a Just Culture approach that prioritises learning, improvement and psychological safety.

All concerns entering the Health Board will undergo an initial triage assessment to determine:

- The nature of the concern
- Actual or potential harm
- Immediate safety risks
- Safeguarding requirements
- Duty of Candour considerations
- Potential qualifying liability
- Complexity and number of organisations involved
- Potential for system learning
- Appropriate resolution pathway

Where safeguarding indicators are identified at triage, safeguarding action must take precedence over Listening to People. The case must be referred through the appropriate safeguarding pathway and advice sought from safeguarding leads. The triage decision must record whether the Listening to People process is suitable, unsuitable, paused, adapted or able to run in parallel with safeguarding processes.

Medical Examiner and Mortality-Related Concerns

Concerns arising from Medical Examiner scrutiny, mortality review, bereavement feedback, inquests or Prevention of Future Death reports are within the scope of this policy where they indicate potential care, treatment, communication, patient safety, safeguarding, Duty of Candour, redress or learning issues. Such concerns must be referred into the integrated triage arrangements and managed through the most appropriate pathway.

Triage must determine whether the matter requires a Listening Discussion, Early Resolution, Stage 2 investigation, patient safety incident reporting, safeguarding referral, Duty of Candour review, redress consideration, legal or inquest input, mortality review action, Clinical Care Group review or escalation to a Concern Management Group. The decision, rationale, accountable lead, communication plan and learning route must be documented.

The outcome of this assessment will determine the most proportionate management route as supported by the integrated triage tool located on our [Listening To People](#) page (opens in a new tab).

The integrated triage decision must identify the accountable Clinical Care Group or service lead, nominated case coordinator, required specialist input, proposed investigation or review methodology, communication arrangements, timescales, escalation route and learning/action tracking requirements.

Concern Management Groups

Concern Management Groups (CMGs) may be convened where concerns involve:

- Moderate, severe or catastrophic harm
- Death
- Complex multi-agency involvement
- Significant organisational risk
- Potential qualifying liability
- Matters attracting significant external scrutiny
- Concerns requiring coordinated oversight and decision making

The purpose of the CMG is to ensure appropriate governance, consistency of approach, timely decision-making, investigation sign-off, escalation, communication alignment and oversight of learning and improvement actions. The CMG will agree the investigation scope, accountable investigation lead, required specialist membership, communication plan, response sign-off route, risk escalation requirements and arrangements for monitoring actions to completion and impact.

CMGs must operate in accordance with the Health Board's agreed terms of reference and integrated concerns governance arrangements.

Investigation Approach

Investigations undertaken within the model will:

- Consider whether equality, diversity, inclusion, language, culture, accessibility or discrimination-related factors contributed to the incident, concern or outcome, and identify any learning or improvement actions arising from this.
- Focus on understanding why events occurred.
- Apply systems thinking and human factors principles.
- Consider organisational, environmental and human contributory factors.
- Seek involvement from patients, families and staff.
- Utilise the most appropriate review methodology.
- Avoid unnecessary duplication of investigations.
- Consider the need for independent clinical review where appropriate.

Investigate Once, Investigate Well

The Health Board is committed to the principle of "Investigate Once, Investigate Well", recognising that concerns often involve multiple reporting, governance and assurance requirements arising from the same event or circumstances.

Where concerns relate to incidents, complaints, claims, safeguarding concerns, Duty of Candour reviews, inquests, Prevention of Future Death reports, Ombudsman investigations or other forms of external scrutiny, the Health Board will seek to undertake a single coordinated review wherever possible.

The purpose of this approach is to avoid duplication, minimise burden on patients, families, unpaid carers and staff, ensure consistency of findings and maximise opportunities for learning and improvement. The Health Board will seek to gather information once, use proportionate review methodologies and ensure that learning generated from a concern meets the requirements of all relevant governance processes.

In applying this principle, the Health Board will:

- Undertake a single integrated triage assessment to determine review, investigation and governance requirements.

- Adopt a proportionate investigation methodology based upon harm, complexity, risk, learning potential and statutory requirements.
- Coordinate reviews across complaints, patient safety, legal, safeguarding, quality and operational functions wherever appropriate.
- Avoid requesting the same information repeatedly from patients, families, unpaid carers or staff unless additional clarification is required.
- Ensure investigation findings, learning and improvement actions are shared across all relevant governance processes.
- Seek to produce a single, coherent understanding of what happened, why it happened and what actions are required to reduce the likelihood of recurrence.
- Promote transparency, compassion and partnership with patients, families, unpaid carers and staff throughout the review process.

The Health Board recognises that different statutory and regulatory processes may, on occasion, require separate consideration. However, wherever possible, these processes will be aligned and informed by a common evidence base to ensure a consistent approach, reduce duplication and support organisational learning.

The aim is not to conduct multiple investigations into the same event, but to develop a single, comprehensive understanding that supports learning, improvement and safer care.

Learning and Improvement

Learning is a fundamental outcome of the Listening to People process and a core component of the Health Board's Quality Management System. Learning must be captured, shared, implemented and evaluated through the Health Board's agreed organisational learning arrangements.

The objective of learning is not simply to understand what went wrong, but to continuously improve what happens next. The Health Board is committed to ensuring that concerns result in meaningful learning, improvement and safer care rather than simply the completion of a process or closure of a case.

Learning identified through complaints, incidents, claims, patient feedback, safeguarding concerns, Duty of Candour reviews, inquests and external scrutiny will be managed in accordance with the Health Board's Organisational Learning Framework.

This ensures that learning is identified, documented, implemented, monitored and evaluated to determine whether meaningful and sustainable improvements have been achieved.

The Health Board adopts the principle that every concern should generate learning, whether the concern is upheld. Learning may relate to patient safety, clinical practice, communication, systems and processes, service delivery, workforce wellbeing, organisational culture or opportunities to share and replicate good practice.

Learning will be co-produced wherever possible with patients, families, unpaid carers and staff. Learning analysis will consider whether themes emerge in relation to protected characteristics, accessibility, discrimination, inequitable access to services or differential outcomes. Where identified, these themes will inform service improvement actions, targeted engagement and organisational learning priorities.

Learning arising from concerns will be captured through agreed mechanisms including Learning Summaries, thematic reviews, 7-minute briefings, after action reviews, quality improvement initiatives and service action plans. Learning will be recorded within the Health Board's learning systems and disseminated through established governance arrangements, including the Learning Library, Clinical Care Groups, professional forums, quality and safety meetings, and the Listening and Learning Sub-Committee.

The effectiveness of improvement actions will be monitored through the Health Board's governance arrangements to ensure that identified actions are implemented, embedded and deliver the intended benefits. Where appropriate, learning will be shared across organisational and professional boundaries to support wider system improvement and reduce the risk of avoidable harm.

Where learning actions are identified, the accountable service lead must ensure that actions are specific, measurable, assigned to named owners, time-bound, recorded in the relevant system, monitored through local governance and escalated where delivery is delayed, incomplete or ineffective. Closure must be based on evidence of implementation and, where appropriate, evidence of impact.

The Health Board is committed to creating a learning culture in which patients, families, unpaid carers and staff are recognised as partners in improvement and where concerns are viewed as valuable opportunities to strengthen the quality, safety and experience of care provided to the population we serve.

Learning identified through the Integrated Patient Safety Triage Model will be:

- Recorded within a Learning Summary.
- Assigned to accountable leads.
- Supported by measurable improvement actions.
- Monitored through governance arrangements.
- Shared across services and teams.
- Reported through quality and safety governance structures.

Escalation must occur where risks remain uncontrolled, actions are overdue, themes indicate wider system risk, external scrutiny is likely, or executive/committee oversight is required.

The objective is to ensure that all concerns contribute to improved patient safety, enhanced patient experience, stronger systems and reduced likelihood of future harm.

Being Open / Duty of Candour

Where the Duty of Candour may apply, the Health Board must review the circumstances promptly to determine whether a notifiable adverse outcome has occurred. The duty is triggered where it appears that a service user has suffered, or could suffer, unexpected or unintended harm that is more than minimal and the provision of healthcare was, or may have been, a factor. When triggered, the relevant person must be notified as soon as reasonably practicable by telephone, audio-visual communication or face-to-face meeting, offered a meaningful apology, provided with an explanation of the information known at that time, advised of next steps, offered support and given a named point of contact. Written notification must follow within five working days of the initial notification in accordance with the Duty of Candour Procedure (Wales) Regulations 2023 and Health Board procedure. Saying sorry is not an admission of liability.

The guidance at [Appendix 3](#) provides the process for reviewing whether the Duty of Candour has been triggered, making the initial notification, providing written follow-up, communicating the outcome of further enquiries, offering support and keeping appropriate records.

Multidisciplinary Responsibility

Most healthcare is delivered through multidisciplinary teams. This should be reflected in the way that patients, families and unpaid carers are communicated with when things go wrong.

The Listening to People process recognises that concerns often arise from system, process and communication factors rather than the actions of a single individual. A multidisciplinary approach supports balanced review, shared learning and coordinated improvement. After action reviews and Concern Management Groups help to achieve this shared responsibility.

Continuity of care

Patients are entitled to expect that they will continue to receive all usual treatment and continue to be treated with dignity, respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, where possible, alternative arrangements should be made.

Nationally Reportable Incidents

As part of the initial assessment process of the incident, the Health Board will need to consider whether an incident requires reporting nationally. Further guidance on this can be found in the Incident Management Procedure or the national policy on patient safety incident reporting:

du.nhs.wales/files/incidents/national-policy-on-patient-safety-incident-reporting-2-0-pdf/ (opens in new tab)

Support for Staff Involved in Concerns

Being the subject of a concern or even reporting a concern as a member of staff can be very stressful. In terms of being the subject of a concern, when an issue is raised, whether by a patient or through a report from a member of staff, the details should be shared with the staff member involved wherever appropriate. This should be done supportively, and staff may want to have a member of their professional association or Trade Union representative present in any meetings.

The Directorate Senior Management Team, Redress Team, Patient Support Team and/or Quality Assurance and Safety Team will provide support for those involved with the formal review of a concern in accordance with the 'assist me' good practice model for supporting staff involved in adverse events (see [appendix 2](#)).

Consideration should also be given under the workforce and organisational development policies as to whether a staff member may need more proactive support such as counselling. In terms of staff who report concerns, consideration should also be given as to whether they may require specific support. For any member of staff involved in a concern, their line manager should be involved in any decisions that are taken.

Training, Competence and Support

The Health Board recognises that delivering the ambitions of Listening to People requires staff to have the knowledge, skills, confidence and support necessary to listen effectively, manage concerns compassionately and undertake proportionate reviews and investigations.

A comprehensive training, development and support framework will be maintained to support staff involved in all aspects of the concerns process. This will include training and development opportunities

appropriate to role and responsibility, including active listening, compassionate communication, trauma-informed practice, early resolution, investigation skills, systems-based learning, Duty of Candour, Just Culture principles, organisational learning, accessible communication, equality and human rights, unconscious bias, anti-racism and cultural awareness.

The Health Board is equally committed to supporting staff who are involved in concerns, whether they are managing a concern, contributing to a review or are the subject of a concern. Staff will be afforded appropriate guidance, supervision and wellbeing support to promote psychological safety, reflective practice and continuous learning.

Competency requirements, role-specific training pathways and supporting resources will be described within associated procedures, guidance documents and training programmes.

NHS Redress Arrangements

Where a concern includes an allegation that harm has been caused because of NHS care or treatment, the Health Board has a statutory duty to consider whether a qualifying liability may exist and whether redress should be offered.

This assessment can only be undertaken as part of a formal investigation under Stage 2 of the Listening to People process and does not form part of Early Resolution arrangements.

A qualifying liability exists where a patient has suffered injury or loss arising from healthcare provided by the NHS and there is evidence that the care fell below the required standard and caused, or materially contributed to, that harm. The assessment includes consideration of duty of care, breach of duty and causation.

Redress aims to provide a fair, timely and person-centred response when harm has occurred and may include:

- A written apology;
- An explanation of what happened;
- A report describing actions taken to prevent recurrence;
- Remedial treatment or care, where appropriate; and
- Financial compensation where the value falls within the statutory redress arrangements.

The Health Board will consider potential qualifying liability at an early stage of the investigation process to ensure an appropriate and proportionate response. Where there is, or may be, a qualifying liability, individuals will be provided with information about the redress process, access to independent legal advice funded through the arrangements, and ongoing support throughout the investigation.

The Health Board is committed to ensuring that redress arrangements operate alongside the principles of openness, compassion, learning, Duty of Candour and continuous improvement, with the primary objective of understanding what has happened, responding fairly and reducing the likelihood of future harm.

Governance Framework

Through the Quality Management System, the Health Board will provide assurance to the Board, its committees, regulators and the public that concerns are managed effectively, learning is embedded and improvements are implemented and sustained.

Information and learning arising from concerns will form part of the Health Board's Quality Management System and will be used alongside patient safety, audit, mortality, safeguarding, patient experience, workforce and performance intelligence to inform quality planning, quality assurance, quality control and quality improvement activities.

The Health Board will seek to collect and analyse equality information, where appropriate, lawful and proportionate, to understand the experiences of people raising concerns and staff involved in concerns. Analysis will be used to identify disparities, trends, barriers to access, allegations of discrimination and opportunities to improve outcomes for people with protected characteristics and underserved communities. Findings and learning will be reported through relevant governance arrangements to provide assurance that the policy is operating fairly and effectively.

Learning from concerns will be triangulated with other sources of organisational intelligence to identify themes, emerging risks, improvement priorities and opportunities for system-wide learning.

All concerns with significant learning will be reported to the Listening and Learning Sub-Committee and an assurance and escalation report provided to the Quality, Safety, and Experience Committee.

Compliance with stated timescales for acknowledgement, early resolution, investigation, response and learning will be monitored and reported through the Health Board's quality and safety governance arrangements. The Board will be made aware of concerns that may present significant risk to patient safety, public confidence or organisational reputation through the appropriate executive and committee reporting routes.

Measuring Effectiveness

The Health Board is committed to ensuring that the Listening to People framework delivers meaningful improvements in patient safety, quality, experience and organisational learning. The effectiveness of the arrangements described within this policy will be monitored through a combination of statutory performance measures, locally agreed service standards and organisational learning indicators.

Performance will be routinely monitored and reported through the Health Board's **Improving Together Performance Framework** and **My Performance Dashboard**, enabling operational teams, Clinical Care Groups, executive leaders and governance committees to oversee performance, identify emerging risks and monitor improvement over time.

To support consistency across the organisation, a suite of service standards and quality measures will be developed and maintained. These will be reviewed periodically to ensure alignment with national requirements, organisational priorities and emerging learning.

Measures of effectiveness may include:

- Equality monitoring and thematic analysis, including access to the process, communication needs, allegations of discrimination, disparities in experience or outcomes, and evidence that identified inequalities have informed improvement action.
- Compliance with statutory and regulatory requirements, including acknowledgement, early resolution, investigation and response timescales.
- Uptake and timeliness of Listening Discussions.

- Early Resolution rates and escalation rates to Stage 2 investigations.
- Compliance with Duty of Candour requirements.
- The quality, completion and effectiveness of investigation action plans.
- Identification, monitoring and reduction of recurrent themes, contributory factors and avoidable harm.
- Evidence of shared learning, dissemination of learning and implementation of improvement actions across services.
- Evidence of impact and improvement resulting from learning, including demonstrable changes to systems, processes, practice and patient experience.
- Timeliness of implementation and evaluation of learning actions.
- Patient, family and staff feedback regarding the concerns process.
- Number and nature of concerns referred to the Public Services Ombudsman for Wales, together with Ombudsman findings, compliance with recommendations and organisational learning arising from those cases.
- Thematic trends identified from complaints, incidents, claims, safeguarding, Duty of Candour reviews, inquests and other sources of quality intelligence.

Performance information and learning outputs will be reviewed through the Health Board's governance arrangements, including the Listening and Learning Sub-Committee, Quality, Safety and Experience Committee and Board, to provide assurance that concerns are being managed effectively and that learning is leading to measurable improvements in care, safety and experience.

The primary measure of success will not solely be the achievement of timescales, but the extent to which concerns lead to learning, improvement and a reduction in the likelihood of future harm.

Roles and Responsibilities

Chief Executive

The Chief Executive has overall accountability for ensuring that the Health Board has effective arrangements in place for the management of concerns, complaints, incidents and redress in accordance with the Listening to People Regulations, the Duty of Quality, the Duty of Candour and wider statutory duties. Operational responsibility for these arrangements is delegated to the Executive Director of Nursing, Quality and Patient Experience, while overall accountability remains with the Chief Executive.

Independent Member of the Board

The nominated Independent Member maintains strategic oversight of the Health Board's concerns arrangements and provides independent assurance to the Board that the organisation listens, responds, learns and improves from concerns. This role includes seeking assurance that:

- Ensuring that the organisation complies with the arrangements it has in place for ensuring that the details of concerns received and investigated are considered so that lessons may be learned to seek to avoid such deficiencies recurring;
- Ensuring that an annual report is prepared which summarises the organisation's activities under the regulations (NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and subsequent amendments for Listening to People. (Regulation 10.2); and
- Ensuring that arrangements for dealing with concerns are published in a variety of media, formats and languages and that a copy of the arrangements is given free of charge to any person who requests it, in the format requested.

Executive Director of Nursing, Quality and Patient Experience (Responsible Officer)

The Executive Director of Nursing, Quality and Patient Experience is the executive lead and Responsible Officer for the Health Board's Listening to People arrangements. The Executive Director is responsible for ensuring that the Health Board operates an integrated, compliant and learning-focused approach to concerns management, including complaints, incidents, claims, redress, Duty of Candour, Medical Examiner concerns, safeguarding interfaces and other relevant quality intelligence.

- ensuring that concerns are managed in accordance with the Regulations and Listening to People guidance;
- ensuring arrangements are in place to consider qualifying liability and redress where appropriate;
- ensuring complaints, incidents, claims, safeguarding interfaces and patient safety intelligence are managed through a coherent governance framework;
- ensuring assurance is provided to the Board and relevant committees on performance, learning, risk and improvement; and
- ensuring escalation arrangements are in place for significant patient safety, legal, safeguarding, reputational or regulatory risks.

The Executive Director delegates defined operational responsibilities to the Assistant Director of Legal Services and Patient Experience and the Assistant Director of Nursing Assurance and Safeguarding. Delegation does not remove executive accountability, and both delegated leads are required to work together to ensure that legal, patient experience, patient safety, safeguarding and assurance requirements are aligned.

Assistant Director of Legal Services and Patient Experience

The Assistant Director of Legal Services and Patient Experience is responsible for the operational leadership of complaints, concerns, redress and legal services interfaces. This includes ensuring that concerns are acknowledged, coordinated, investigated and responded to in accordance with statutory requirements, and that qualifying liability, redress, claims, inquests, Ombudsman matters and legal risks are considered and escalated appropriately.

Assistant Director of Nursing Assurance and Safeguarding

The Assistant Director of Nursing Assurance and Safeguarding is responsible for the operational leadership of patient safety assurance, safeguarding interface, incident management, organisational learning and quality governance within the integrated arrangements. This includes ensuring that incidents, adverse events, Medical Examiner concerns, safeguarding interfaces, Duty of Candour considerations and wider quality intelligence are triaged, escalated and governed appropriately.

The Assistant Director of Legal Services and Patient Experience and the Assistant Director of Nursing Assurance and Safeguarding will jointly ensure that concerns are managed through an integrated approach, avoiding duplication and supporting the principle of "Investigate Once, Investigate Well".

Executive Directors and Directors

All Executive Directors and Directors are responsible for supporting implementation of this policy within their portfolios. They must ensure that services have effective arrangements to identify, escalate, investigate and learn from concerns, and that risks, themes and improvement actions are reported through the appropriate governance routes.

Quality, Assurance and Safety, Patient Support, Legal Services and Safeguarding Teams

Specialist teams provide advice, coordination and oversight to support services in managing concerns. Their role includes supporting triage, investigation methodology, communication with those raising concerns, Duty of Candour, redress, legal interface, safeguarding advice, learning summaries, action tracking, thematic analysis and escalation. These teams support operational services but do not remove accountability from Clinical Care Groups and service leads for investigation quality, implementation of actions and improvement impact.

Specialist teams will also support integrated triage, CMG coordination, quality assurance of investigation outputs, consistency of response letters, sign-off processes, identification of learning, action tracking, thematic reporting and escalation to the Listening and Learning Sub-Committee, Quality, Safety and Experience Committee or executive leads where required.

Clinical Care Groups

Clinical Care Groups are accountable for responding to concerns relating to their services, ensuring proportionate and timely review, identifying learning, implementing improvement actions and demonstrating impact. They are supported by specialist patient support, quality, patient safety, safeguarding and legal teams, but retain responsibility for the quality and timeliness of operational responses and action delivery.

Clinical Care Groups have responsibility to make sure that the principles outlined within this policy are implemented within their Care Group including fostering a culture for learning from experience and sharing lessons learned.

Clinical Care Groups must ensure that trained staff are available to undertake proportionate reviews and investigations, that investigation leads are clearly identified, and that appropriate clinical, managerial and professional oversight is provided. They must work closely with the nominated coordinator from the relevant concerns, patient safety, safeguarding or legal team.

They are responsible for disseminating lessons learned to colleagues within their area of responsibility, and across the Health Board, providing opportunities for learning through team meetings, shared learning events and with colleagues in other directorates where appropriate. A 7 minute style briefing will be required for every stage 2 complaint to demonstrate learning. These will be stored on the learning library and utilised to identify themes and trends for priority action, and to inform the priorities for the quality improvement process.

Clinical Care Groups must ensure that learning, actions and evidence of implementation are recorded in the appropriate systems, including Datix and AMaT where applicable, and monitored through local and organisational governance arrangements until completed and evaluated for impact.

Clinical Care Groups are responsible for approving investigation findings within their governance arrangements before final response sign-off, ensuring that conclusions are evidence-based, actions are deliverable and learning is shared with affected teams and across the organisation where relevant.

Heads of Service / Departmental Managers

Heads of Service and Departmental Managers are responsible for creating a local culture in which concerns are welcomed, staff feel able to speak up, and learning is used to improve quality, safety and experience.

They must ensure that concerns are identified, acted on and escalated promptly, and that staff have the knowledge, skills, capacity and support required to contribute to early resolution, reviews, investigations, Duty of Candour processes and learning.

Ensuring staff have the knowledge and skills to manage concerns and capacity to undertake the required investigations, receiving appropriate support and guidance throughout.

They are responsible for disseminating lessons learned to colleagues within their area, and across the Health Board where required, providing opportunities for learning through team meetings and with colleagues in other divisions where appropriate.

Safeguarding Leads

Safeguarding leads are responsible for advising on concerns that include actual, suspected or potential abuse, neglect, exploitation, deliberate harm or risk to a child or adult at risk. They will ensure that safeguarding concerns are managed in accordance with the All Wales Safeguarding Procedures and relevant Health Board safeguarding policies. Safeguarding requirements take precedence over Listening to People, and safeguarding leads must advise whether Listening to People activity is suitable, unsuitable, paused, adapted or able to run in parallel without compromising safeguarding enquiries or multi-agency protection arrangements.

Medical Examiner Service Interface

Where concerns arise from Medical Examiner scrutiny, these must be referred into the appropriate integrated triage arrangements. The relevant service, supported by patient safety, patient experience, legal and safeguarding leads as required, must consider whether the concern requires Listening to People, Duty of Candour, patient safety incident reporting, safeguarding referral, redress consideration, inquest preparation or other governance action.

All Staff

All staff are responsible for ensuring that they:

- listen respectfully and respond compassionately when concerns are raised;
- act immediately where there is an urgent safety or safeguarding risk;
- report incidents, concerns, near misses and adverse events through the appropriate route without delay;
- escalate safeguarding concerns through the All Wales Safeguarding Procedures and local safeguarding pathways;
- co-operate fully, openly and honestly with reviews, investigations and Duty of Candour processes;
- support early resolution where appropriate and within their role;
- participate in learning and improvement activity arising from concerns; and
- follow this policy and associated procedures, guidance and written control documents.

Culture

The Health Board is committed to ensuring that the action and learning from all concerns will be incorporated within the whole organisation to ensure the safety of patients and staff.

To promote this philosophy and ensure staff feel confident **whether they are the subject of a concern or are** the reporter or witness of an incident, we will ensure managers take a fair, equitable and consistent approach when they review concerns. Most concerns including serious incidents will not lead to individuals being managed under a workforce policy.

Within the spirit of being open and fair, a workforce process will only be considered where information highlights potential issues of alleged personal or professional misconduct, capability or other matters that require consideration under relevant workforce policies. To support this approach, the Health Board will follow the principles of a Just Culture.

References

National legislation, statutory guidance and national policy

Welsh Government. Listening to People: NHS Wales complaints, incidents and redress process. First published 1 April 2026; last updated 25 June 2026.

Welsh Government. Listening to People: The NHS Wales Complaints, Incidents and Redress Process – People's Guidance. 2026.

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023 and 2025.

Health and Social Care (Quality and Engagement) (Wales) Act 2020.

Welsh Government. Duty of Quality Statutory Guidance 2023 and Health and Care Quality Standards 2023.

The Duty of Candour Procedure (Wales) Regulations 2023.

Welsh Government. Duty of Candour Statutory Guidance 2023.

Public Services Ombudsman for Wales. Complaints Standards Authority: Principles for Complaint Handling.

Welsh Government. Patient safety incident reporting and management (WHC/2023/017). 2023.
NHS Wales Executive. National Policy on Patient Safety Incident Reporting and Management. Version 2.0, 2023.

Wales Safeguarding Procedures. Wales Safeguarding Procedures.

Welsh Government. Safeguarding guidance, including Working Together to Safeguard People statutory guidance.

Social Services and Well-being (Wales) Act 2014.

NHS Improvement. A Just Culture Guide.

World Health Organization. Patient safety fact sheet.

World Health Organization. Global Patient Safety Report 2024.

Putting Things Right – Management of Concerns Guidance. Retained for historic context only for concerns received up to and including 31 March 2026; Listening to People applies to concerns received from 1 April 2026.

Health Board supporting written control documents

Being Open / Duty of Candour Procedure.

[982 – Incident, near Miss and hazard Reporting Policy](#) – opens in a new tab

[429 - Management and Distribution of Safety Alerts and Notices](#) Policy – opens in a new tab

[004 - Claims Management Policy](#) – opens in new tab

[018 - Staff Attending Inquests / Court and Assisting with Police Investigations Guideline](#) – opens in new tab

[558 - Management of Nursing and Midwifery Medication Errors / Near Misses Policy](#) – opens in new tab

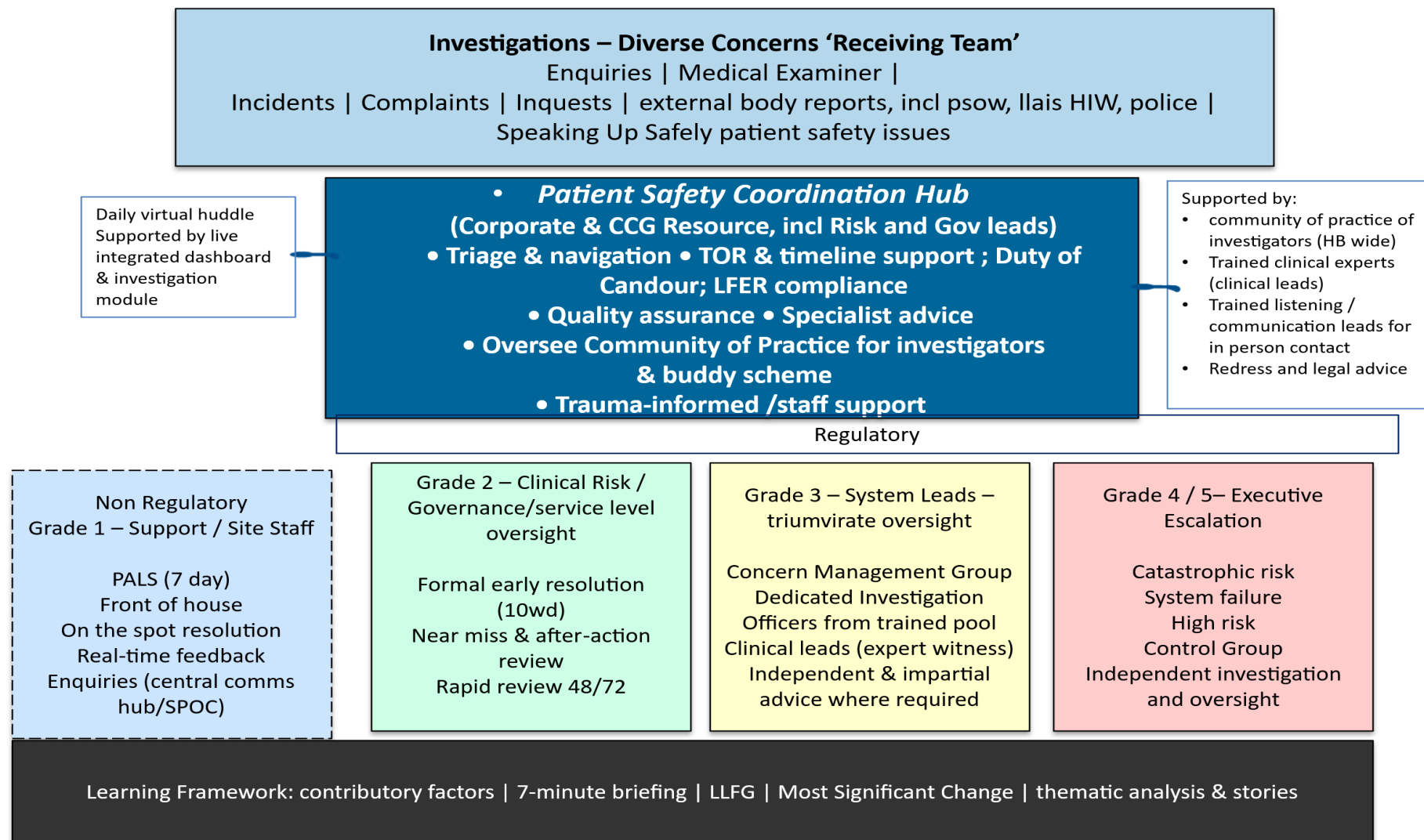
All Wales Safeguarding Procedures and relevant Health Board safeguarding policies must be followed where a concern includes actual, suspected or potential abuse, neglect, exploitation, deliberate harm or risk to a child or adult at risk.

Safeguarding and workforce supporting written control documents

- Safeguarding Adults at Risk Interim Policy (098)
- All Wales Child Protection Procedures
- Procedural Response for Unexpected Deaths in Childhood Procedure (PRUDIC) (563)
- Safeguarding Children & Young People in Emergency and Out of Hours Service Procedure (405)
- Allegations against Employees of Hywel Dda University Health Board of Harm/Abuse Involving Children or Adults (246)
- All Wales Disciplinary Policy & Procedure (201)
- All Wales Capability Policy (203)
- All Wales NHS Staff to Raise Concerns Procedure (435)

Appendix - Integrated patient safety structure

Integrated Patient Safety Structure



Appendix 2 – Levels of Harm Framework

LEVELS OF HARM FRAMEWORK

The examples listed are meant only to be a guide and not an exhaustive list.

Level of harm	Incidents that <u>would not</u> trigger the duty of candour procedure
None	Any patient safety incident that had the potential to cause harm but impact resulted in no harm having arisen. e.g: Appointment delayed, but no consequences in terms of health. e.g: Patient fall – where no harm was suffered or additional interventions required. e.g: Near miss – where the potential for harm was noticed and action taken to avoid occurrence of harm.
Low harm/minimal harm	Any patient safety incident that resulted in a minor increase in treatment and which caused minimal harm to one or more persons receiving NHS-funded care. Minor increase in treatment could include: e.g: First aid, additional therapy, medication or rehabilitation e.g: Patient fall - requiring one off observations and/or minor treatment. e.g: Increase in length of stay by 1 - 3 days.
	When does the duty of candour apply? IMPORTANT- this section sets out the conditions that must be satisfied in order for the duty of candour to apply. These must be worked through when applying the harm framework.^{1} The duty is triggered in relation to an NHS body if it appears to the body that both of the following conditions are met: (1) The first condition is that a person (the “service user”) to whom health care is being or has been provided by the body has suffered an adverse outcome. (2) The second condition is that the provision of the health care was or may have been a factor in the service user suffering that outcome. A service user is to be treated as having suffered an adverse outcome if the user experiences, or if the circumstances are such that the user

¹ For further guidance on determining whether the duty applies, please see Annex A and Annex H and part 4, page 7 of the Guidance.

	could experience, any unexpected or unintended harm that is moderate or above. The duty may be triggered by an action taken by a NHS body during the provision of health care or by a failure to take action. The duty is not triggered where harm is related to the natural course of the service user's illness or underlying condition.
Unexpected or unintended moderate harm	Examples of unexpected or unintended levels of moderate harm and types of incidents that <u>would</u> trigger the duty of candour procedure include: Moderate harm – (a) moderate increase in treatment and (b) Significant but not permanent harm. Moderate increase in treatment could include: • An unplanned admission/re-admission, • An unplanned return to surgery, • Increase in length of stay by 4 -15 days, • Cancelling/postponement of treatment, • Transfer to another treatment/care area, such as secondary care or intensive care as a result of the incident. Examples of the type of incidents that would trigger the duty of candour procedure include: Description of incident – unplanned admission. Patient was seen by a member of the community MH team; who fails to recognise, or act on evidence of poor medication compliance/failure to adhere to treatment sessions/expression of suicidal thoughts. Level of harm as a result - the patient self-harms, causing moderate harm requiring admission to hospital. Description of incident - Operation cancelled. Level of harm as a result – Leading to deterioration and a longer stay in hospital > 4 days and recovery delayed. Description of incident - Patient receives opioids despite this being documented as an allergy. Level of harm as a result – Leading to the patient suffering a significant reaction and required emergency treatment. Description of incident - A mother had significant post-partum haemorrhage after a difficult delivery, and there was a delay in obtaining blood for transfusion.

	Level of harm as a result – Leading to mother being transferred to the high dependency unit as a result of the post-partum haemorrhage and the delay in obtaining blood for the transfusion meant that her recovery was prolonged. The service user experiencing psychological harm: Psychological harm – means a psychiatric condition or the exacerbation of an existing psychiatric condition for a continuous period of at least 28 days. NB: The timeframe above should be used as a measure only. The focus must be on the level of unintended or unexpected harm. <u>Further detailed case study examples can be found in Annex H.</u>
Unexpected or unintended severe harm	Examples of unexpected or unintended levels of severe harm and types of incidents that <u>would</u> trigger the duty of candour procedure include: Severe harm would include: • Avoidable, permanent harm or impairment of health or damage leading to incapacity, disability or the loss of recovery potential. • Avoidable permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage. • Increased length of stay by >15 days Examples of the type of incidents that would trigger the duty of candour procedure include: Description of incident - loss of recovery potential. Delays in thrombolysis or AHP treatment. Level of harm as a result - resulting in loss of recovery of walking or speech, which is permanent. Description of incident - Patient suffers an adverse reaction to medication that they are documented to be allergic to. Level of harm as a result – Leading to the patient suffering brain damage or other permanent organ damage.

	Description of incident - Patient suffer a perforation of the bowel during surgery. Level of harm as a result – Leading to patient requiring a colostomy and/or subsequent operations. Description of incident - Patient did not receive a planned follow up x-ray. Level of harm as a result - Patient was subsequently found to have lung cancer. The chances of survival had been significantly reduced by the 18 month delay in the follow up x-ray being performed. <u>Further detailed case study examples can be found in Annex H of the Duty of Candour Guidance</u>
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Unexpected or unintended death	<u>Examples of unexpected or unintended death and types of incidents that would trigger the duty of candour procedure include:</u> Examples of the type of incidents that would trigger the duty of candour procedure include: Description of incident - Wrong blood transfused. Level of harm as a result - Leading to multi-organ failure and a fatal cardiac arrest. Description of incident - Patient suffers an adverse reaction to medication that they are documented to be allergic to. Level of harm as a result - Leading to severe anaphylaxis and subsequent death. Description of incident - Patient presents with chest pains and is asked to wait in clinic/practice/emergency department. Level of harm as a result - Patient suffers a fatal myocardial infarction in the waiting area, which they then die from.
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Appendix 3 – Supporting Staff – Assist me model

The Assist Me model provides a practical framework for supporting staff involved in adverse events and concerns. Managers should ensure timely acknowledgement of the impact on the staff member, clear information about the process, access to appropriate practical and emotional support, regular communication, opportunities for reflection and learning, and follow-up to review wellbeing and any continuing support needs. The model should be applied alongside workforce wellbeing, occupational health, professional support and trade union arrangements as appropriate. A readable version of the model should also be made available through the Listening to People staff resources page.



THE ASSIST ME MODEL - SUPPORTING STAFF FOLLOWING PATIENT SAFETY INCIDENTS

The importance of support for staff from line managers, colleagues and peers in the aftermath of a patient safety incident should not be underestimated. Being available for staff and hearing/acknowledging their story surrounding the event is crucial. Staff require a safe and confidential space in which to discuss the incident and can find this therapeutic.

A	ACKNOWLEDGE with empathy the incident that has occurred and the impact on the member of staff. ASSESS the impact of the incident on the member of staff and on their ability to continue normal work.
S	SORRY - express regret for what has happened and for their experience.
S	STORY - allow time and space for the member of staff to talk about what happened and how they are feeling. Demonstrate understanding. Share experience, as appropriate.
I	INQUIRE - encourage questions. INFORMATION - provide information.
S	SUPPORTS AND SOLUTIONS ♦ Informal Emotional Support: Demonstrate empathy and compassion. Be available and accessible to provide support, as required. ♦ Formal Emotional Support: Assess any immediate needs and discuss supports available including referral process, e.g. HSE Employee Assistance Programme (EAP), Occupational Health and/or GP. ♦ Practical Support: Discuss and agree immediate working arrangements e.g. ability of staff member to continue with normal duties - consider allocation to other duties, as appropriate. Provide contact details for staff liaison person.
T	TRAVEL - provide continued support and reassurance going forward and throughout the incident review/open disclosure process.
M	MAINTAIN contact and ongoing communication. MONITOR progress - check in regularly with the staff member. MOVE forward with guidance and support.
E	END - close this support process when the staff member feels ready. Remain available. EVALUATE the staff members experience of the support process and use learning to benefit other staff.

NOTE: This model has been adapted from the MPS Assist Model of Communication

Visit the HSE Open Disclosure website where you can access the full ASSIST ME staff support booklet.
www.hse.ie/opendisclosure

Employee Assistance Programme (EAP) is a free confidential course that provides and offers support for you or your team when required and following a critical incident.

EMPLOYEE ASSISTANCE PROGRAMME (EAP)

CALL 0818 327 327

Go to www.hse.ie/EAPandME to access the full range of helpful resources.



Appendix 4 – Duty of Candour Trigger Review Process and Candour Procedure

HDUHB Duty of Candour Procedure

Incident has been reported and recorded via DatixCymru and also the patient care record. A review of the incident is undertaken by a member of the Service Management Team. Dependent upon the severity of the incident, based on the information available at that time, the conditions set out in Annex A, have been met and a duty of candour applies.

Notification

On first becoming aware the duty has been triggered, (which is the start date for the duty of candour procedure to be followed), the HB must notify the service user/or person acting on their behalf as soon as possible.

NB: Where the in-person notification is later than 30 working days after the date on when the NHS body first became aware of the notifiable adverse outcome, an explanation of the reason for this delay should be provided and recorded. *This does not mean that the NHS body has one month to make the notification and communicate.*

The initial notification should be **‘in person’ (telephone, video call, face to face)** by an appropriate senior individual within the service (clinician or manager)

Which method of in person communication is most appropriate will depend on the individual circumstances, including the preference of the service user).

Advice is available from a Duty of Candour Advisor*

Purpose of the in person notification

- | | |
|--|--|
| <ul style="list-style-type: none">• Acknowledge what has happened• Offer an apology• Explain what information is known at that time about what has happened. | <ul style="list-style-type: none">• Explain the next steps in relation what will happen next• Offer support• Provide point of contact details. |
|--|--|

Once in person notification has been made, the Service should provide **written notification** to the service user/person acting on their behalf within **five working days in accordance with template guide and record the date sent and details of the communication.**

The letter will also need to be uploaded to datix

Purpose of the written notification

- Reiterate the verbal apology
- Detail any initial information on what is known about what has happened.
- Explain the intended actions to and further enquiries that the NHS body will undertake

MAKING A MEANINGFUL APOLOGY

It is of fundamental importance that the service user /person acting on their behalf receives a sincere apology in a timely manner that is clear and made in an emphatic way. The objective here is to address the need for information, clarify what has happened and to enable the recipient the opportunity to process what has happened in a supportive environment.

Preparation

It is essential to take the time to prepare for the communication with the service user/person acting on their behalf and any family members. Plan out what you are going to say and discuss this with a senior or peer. Ensure you have adequate time and are not distracted or likely to be interrupted. Being mentally 'present' and able to concentrate is very important part of your preparation. Also think about the needs of the service user/person acting on their behalf – what information do they need and how and what support may they need? (Refer to part 7 of the candour guidance document).

What has happened (be clear what is known and what is not yet known), **Who** is best to deliver this information, **When** is it best to deliver this and **How** you intend to deliver this. It is important to recognise that the '**Why** this has happened' is the purpose of the investigation process and not usually part of the apology at this early stage. Although it is common for Service Users/person acting on their behalf to ask this at this stage. It is acceptable to be honest and say that you are not certain of that at this point in time.

Delivery

You are imparting 'bad news' to a service user/person acting on their behalf, sometimes they are aware of an unexpected or unintended harm but not fully aware of the circumstances or they can be unaware of the unintended or unexpected harm outcome that has occurred. Be clear and factual and avoid jargon. Starting with an introduction of who you are and checking who it is you are talking to and who else is present.

Explain the reason why you are talking to them.

Inform the Service User of the unintended or unexpected harm and what actually is known to have occurred. Show that the circumstances and the impact for the person affected are understood e.g. 'you were left not knowing what was happening'

Accept and acknowledge what should have happened 'We should have explained exactly what was going to occur to you'

Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full [EqIA](#).

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the [EqIA Sharepoint](#) or contact:

Email: Inclusion.hdd@wales.nhs.uk

Tel: 01554 899055

Director and Directorate	Executive Director of Nursing, Quality and Patient Experience
Service Area	Legal and Patient Support Services

Title of Procedure, Project, Proposal, Policy being screened:	894 'Listening to People' Integrated Patient Safety, Concerns Management and Resolution Policy
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**Description of the Procedure/ Project/ Proposal/ Policy being screened
(including key aims and objectives)**

The aim of this policy is to establish a single, integrated and person-centred approach to the management of concerns, ensuring that patients, families, carers and staff are listened to, treated with compassion and respect, and supported throughout the process.

Through timely, proportionate and transparent review of concerns, the Health Board seeks to understand not only what happened, but why it happened, so that learning can be translated into meaningful improvement, safer care, better experiences and improved outcomes for the people and communities we serve.

This policy aims to:

- Promote a culture of openness, compassion, professionalism and continuous improvement, where feedback, concerns and adverse events are welcomed as opportunities to learn.
- Ensure compliance with the Listening to People framework, the Duty of Candour, the Duty of Quality and all relevant statutory and regulatory requirements.
- Create an environment of psychological safety in which patients, families, carers and staff feel confident to speak up, raise concerns, share experiences and contribute to learning without fear of blame or disadvantage.
- Ensure concerns are reviewed in a timely, proportionate and person-centred manner, with the level of review informed by risk, harm, complexity and learning potential.
- Support a Just Culture approach that seeks to understand human, organisational and system factors contributing to events, promoting learning and improvement rather than inappropriate blame.
- Use intelligence from concerns, incidents, complaints, claims, letters from the medical examiner, patient feedback and staff experiences to identify themes, reduce avoidable harm and drive service improvement.
- Ensure learning is translated into demonstrable improvements in patient safety, quality of care, patient experience and workforce wellbeing.
- Support staff involved in incidents, complaints, investigations and claims, recognising the importance of wellbeing, reflective practice and compassionate leadership.

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

This policy replaces the previous Putting Things Right approach with an integrated Listening to People framework. It brings together concerns, complaints, patient safety incidents, claims and redress, alongside related interfaces such as Medical Examiner cases, inquests, safeguarding referrals and external reviews, within a unified patient safety and learning system.

The purpose is to establish a single integrated framework for listening, responding, resolving, learning and improving from concerns, patient safety events and feedback.

This policy applies to all staff who have a responsibility to identify, receive, report, acknowledge, triage, manage, investigate, review, respond to, learn from or provide assurance in relation to concerns. It applies regardless of how the concern enters the organisation, including concerns raised directly by patients, families, carers or representatives; complaints; incidents; near misses; adverse events; staff-reported patient safety issues; Medical Examiner communications; mortality review findings; inquests; Prevention of Future Death reports; claims; redress considerations; safeguarding concerns; commissioned service concerns; independent contractor issues; Ombudsman matters; regulator feedback; external scrutiny; or other quality, safety, experience or governance intelligence.

The policy covers concerns relating to NHS-funded care, treatment, support, communication, access, experience, safety, quality, professional practice, systems, processes and outcomes where Hywel Dda University Health Board is the responsible body, provider or commissioner.

In terms of the effective management, formal review and resolution of concerns, with an approach that is person centred, the Health Board is committed to the principles of openness, accessibility, transparency, responsiveness, fairness and confidentiality. In line with national equality and diversity legislation, the Board takes all reasonable steps to enable patients, their representatives and our staff to raise a concern in the most appropriate format to them. It also offers the support of advocacy services where necessary, working collaboratively with Hywel Dda Community Health Council. This policy provides an objectives framework to govern the procedures for addressing complaints and concerns. It will be the responsibility of staff involved in addressing concerns to ensure that the principles and guidance within this policy is duly followed and that consideration is given to the protected characteristics, where relevant, when following due process.

The policy is intended to make the concerns management process as quick and as fair as possible, with concerns being assessed on the basis of facts and in accordance with the Regulations. It is therefore considered that the impact is primarily positive.

No potential adverse impacts in relation to any protected characteristics have been identified at this stage. A search of similar policies elsewhere indicated similar results.

Whilst no potential adverse impacts in relation to any protected characteristics have been identified at this stage, staff involved in addressing concerns will need to be sensitive to issues in relation to sharing sensitive personal information where required e.g. Transgender status, sexual orientation etc. Each concern is assessed on the basis of facts and in accordance with the law. The Health Board has a legal obligation to provide all information it holds relating to the concern in accordance with the Putting Things Right Regulations. Sharing of personal identifiable information risks have been mitigated by following the Health Board's Information Governance policies and procedures and national guidance/legislation regarding confidentiality and data protection

Associated policies and references can be found on pages 28/29 of the policy.

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact).

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqlA must be undertaken: [Equality Impact Assessments \(EqlAs\) \(sharepoint.com\)](https://sharepoint.com)

Age

Is it likely to affect older and younger people in different ways or affect one age group and not another?

Positive Impact	✓	Negative Impact		No Impact	
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Justification of impact identified: This is an administrative body of work that will be positively used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board and will not have any impact due to age.

Disability

Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?

Positive Impact	✓	Negative Impact		No Impact	
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Justification of impact identified:

The Health Board is committed to ensuring concerns can be raised in a way that is accessible and convenient for individuals. Concerns may be raised verbally, in writing or electronically and can be made through the Health Board's published concerns arrangements, available via its website and other communication channels. [Patient support services \(complaints & feedback\) - Hywel Dda University Health Board](#)

Individuals will be offered reasonable adjustments, language support and advocacy where required to ensure equitable access to the concerns process. Concerns may be raised with any member of staff, who has responsibility for ensuring the concern is directed into the appropriate process.

Gender Reassignment

Is it likely to affect those who either:

- Have undergone, intend to undergo or are currently undergoing gender reassignment.

Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth				
Positive Impact	✓	Negative Impact		No Impact
Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board the LTP process will have a positive impact due to and gender reassignment.				
Marriage / Civil Partnership Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment. Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.				
Positive Impact		Negative Impact		No Impact
Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board and will not have any impact due to their marriage or civil partnership status.				
Pregnancy and Maternity Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.				
Positive Impact	✓	Negative Impact		No Impact
Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board the LTP policy will primarily have a positive impact for people raising concerns that might be pregnant or recently had a baby.				
Race / Ethnicity Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?				
Positive Impact	✓	Negative Impact		No Impact
Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board. The LTP policy will have a positive impact due to race or ethnicity.				
Religion or Belief Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.				
Positive Impact	✓	Negative Impact		No Impact
Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board and will primarily have a positive impact due to religion or beliefs.				
Sex Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?				
Positive Impact	✓	Negative Impact		No Impact
Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board. The LTP policy will have a positive impact it applies equally and does not affect one differently than the other.				

Sexual Orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or either.					
Positive Impact	✓	Negative Impact		No Impact	
Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board the LTP policy will have a positive impact regardless of a person's sexual attraction is towards their own sex, the opposite sex or either.					
Armed Forces Community Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.' For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: Armed-Forces-Covenant-duty-statutory-guidance					
Positive Impact	✓	Negative Impact		No Impact	
Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board and will have a positive impact to the armed forces community.					
Socio Economic Duty Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered. For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see: more-equal-wales-socio-economic-duty					
Positive Impact	✓	Negative Impact		No Impact	
Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board the LTP policy will have a positive impact due to their socio economic position.					
Welsh Language Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: This is an administrative body of work that will be used to support patient, family member, carer or advocate who wishes to raise their concerns with the Health Board and will not have any impact on the use of the Welsh language.					

If a negative impact has been identified, you are not required to complete this form as a full EqlA must be undertaken. A full EqlA template and guidance can be found on the following link: [Equality Impact Assessments \(EqlAs\) \(sharepoint.com\)](#)

Screening Completed by:	Name	Clare Dix
	Title	(Hywel Dda UHB - Team Administrator)
	Contact details	Clare.dix@wales.nhs.uk
	Date	26/08/2026
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	Louise O'Connor
	Title	Hywel Dda UHB Assistant Director (Legal and Patient Support Services)
	Contact details	louise.oconnor@wales.nhs.uk
	Date	08/09/2026
Guidance has been provided by Diversity & Inclusion Team:	Name	Alan Winter
	Title	Senior Diversity & Inclusion Officer
	Contact details	Alan.winter@wales.nhs.uk
	Date	29/9/2026
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqlA and inform the D&I team.