



Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	05 October 2023
TEITL YR ADRODDIAD: TITLE OF REPORT:	Written control documentation – Patient Experience and Legal
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mandy Rayani, Executive Director of Nursing, Quality & Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Louise O'Connor, Assistant Director, Legal & 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 Quality, Safety and Experience Committee (QSEC) is asked to approve the attached policies which have recently been subject to staff consultation:

- 004 – Claims Management Policy (Appendix 1)

No significant changes were made to the policy. Some additions/corrections were made in line with Information Governance regulations.

- 894 – Management of Concerns Policy (Appendix 2)

Minor typographical amendments were made. Responsibilities for learning were clarified following internal audit recommendations around lessons learned.

QSEC is asked to support further extensions to the review dates of the following documents:

- 018 – Staff Attending Inquests/Court and Assisting Policy Investigation Guideline – for discussion at Listening and Learning Sub-Committee on 11 October 2023.
- 063 – Use of Patient and Carers Stories Guideline – due to revised national guidance being issued to Listening and Learning Sub-Committee on 11 October 2023
- 307 – Production of Patient and Carer Information Policy – subject to staff consultation.

The QSEC is asked to approve extensions to the review dates of the following documents for a further three months, enabling further multi-directorate review:

- 568 – Production and Use of Surveys Guideline

Cefndir / Background

It is imperative that Hywel Dda University Health Board (HDdUHB) has up to date and accurate written control documentation in order to comply with relevant legislation/regulations and minimise any associated risk.

Asesiad / Assessment

The extension date to each written control document has been determined by the lead officers and assurance has been provided by the lead authors that the documents remain fit for purpose during the extension period.

Argymhelliad / Recommendation

For QSEC to approve the following policies:

- 004 – Claims Management Policy
- 584 - Management of Concerns Policy

QSEC is asked to agree to an extension to the review dates for the following documentation:

- 018 – Staff Attending Inquests/Court and Assisting Policy Investigation Guideline
- 063 – Use of Patient and Carers Stories Guideline
- 307 – Production of Patient and Carer Information Policy

QSEC is asked to extend the following guideline for three months:

- 568 – Production and Use of Surveys Guideline

These policies have been updated in relation to recent guidance and will be presented to the Listening and Learning Sub-Committee in October 2023.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	QSEC – 3.22
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable

Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	As detailed in each written control document
Rhestr Termau: Glossary of Terms:	As detailed in each written control document
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Yes
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Yes

Enw Da: Reputational:	Yes
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Each written control document has its own Equality Impact Assessment. This will be fully reviewed was part of the review process

Claims Management Policy

Policy information

Policy number: 004

Classification:
Corporate

Supersedes:
Previous Version

Version number:
4.0

Date of Equality Impact Assessment:
Detail date of EqIA

Approval information

Approved by: QSEAC

Date of approval:
Enter approval date

Date made active:
Enter date made active (completion by policy team)

Review date:
Enter review date (normally three years from approval date)

Summary of document:

Defines the Health Board policy, roles and responsibilities in the handling of Redress matters, Clinical Negligence claims, Personal Injury claims and General Medical Practice Indemnity claims (GMPI).

This policy does not cover small claims and claims that do not have an element of personal injury to them such as damage to property, road traffic collisions, see link below at paragraph 6.17 for further information.

Scope:

The policy applies to members of staff employed by the Hywel Dda University Health Board (permanent and non-permanent) and, in certain circumstances, to contractors and those who work on behalf of contractors.

To be read in conjunction with:

All Wales Putting Things Right Guidance

[982 Incident, near miss and hazard reporting policy](#) – opens in a new tab

[156 Risk Management Strategy & Policy](#) – opens in a new tab
[066 - Losses and Special Payments Procedure](#) – opens in a new tab
[347- Corporate Records Management Policy](#) – opens in a new tab
[192- Health Records Management Policy](#) – opens in a new tab
[1088- Information Right Procedure](#) – opens in a new tab
[249- Access to Health Records Policy](#) – opens in a new tab
[836- All Wales Information Governance Policy](#) – opens in a new tab
[193- Retention and Destruction of Records Policy \(Including Health Records\)](#) – opens in a new tab
[172- Confidentiality Policy](#) – opens in a new tab

Owning group:

Listening and Learning Sub Committee

12/07/2023

Executive Director job title:

Mandy Rayani – Director of Nursing, Quality and Patient Experience

Reviews and updates:

1.0 – New Policy

2.0 – Revised

3.0 – Full Review

4.0 – Full Review and Revision

Keywords

Claims, management, Clinical Negligence, Redress, Personal Injury

Glossary of terms

Term	Definition
Clinical/Medical Negligence - Liability	Where it is established that the duty of care owed by the Health Board via its staff/systems has been breached and harm and/or loss has been caused as a result of that breach. A breach of duty is said to have occurred where the standard of care provided has fallen below that expected of a responsible body of doctors, nurses, allied professionals, or other members of staff.
Personal Injury	Where harm has been caused to a member of staff, patient, visitor, due to a breach of the relevant employment regulations/Occupiers Liability Act 1957/1984.
National Health Service Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011	These regulations form the statutory framework under which incidents, complaints and concerns regarding patient care are managed and decisions are made about whether or not a Qualifying Liability (QL) exists and, if so, whether redress is required. A QL is said to exist where the standard of care has fallen below the standard required (as in breach of duty above) resulting in harm or loss to the patient. It should be noted that there is a distinction between the process for managing a concern/complaint (under part 5 of the regulations) and the process for managing redress (under part 6 of the regulations).

Redress	Where a qualifying liability exists, redress can be given in a number of different forms such as an apology, remedial treatment and/or financial compensation
Public Service Ombudsman	PSO investigates complaints/concerns made in relation to the provision of health services and other public services and, subject to his findings, he can instruct Health Boards to apologise or make payments following his conclusion.
NWSSP Legal and Risk	NHS Wales Shared Services Partnership, Legal and Risk Services provides legal advice and representation to Health Bodies in Wales in clinical negligence and person injury matters and can advise in other areas of law.

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Introduction

The Health Board has a duty of care towards its patients/clients/service users, its staff and members of the general public.

When the duty of care has been breached, the matter will be dealt with in one of 3 ways:

1. Under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, locally known as the Putting Things Right (PTR) Regulations if the matter relates to the care of a patient and the value, if successful, is estimated to be under £25,000. If, during an investigation, it becomes apparent that the value of the case sits just above the £25,000 ceiling, settlement can still be negotiated outside of the regulations if both parties agree.
2. In matters where damages are estimated to be over £25,000 at the outset or where a patient does not want their complaint to be dealt with under the PTR regulations, the matter will be managed through the Pre-action Protocol for the Resolution of Clinical Disputes provided for within the Civil Procedure Rules. It will be conducted jointly by the in house legal services team and Legal and Risk Services – solicitors employed directly by the NHS and based in the NHS Wales Shared Services Partnership (NWSSP).
3. For matters relating to staff or visitors to the hospital or where personal injury has occurred to a patient which is not related to care and treatment, it will be dealt with under the Pre- action Protocol for Personal Injury which can be found in the Civil Procedure Rules.

For a claim to be successful, a claimant must prove:

- that he/she was owed a duty of care by the Health Board;
- that the duty was breached; and
- that the breach of duty identified caused, or materially contributed to, harm or loss.

Civil claims have a statutory time limit under The Limitation Act 1980 known as “limitation.” It provides that proceedings must be issued within three years of the date of the incident, 3 years from the date a claimant becomes aware that he/she has or may have suffered harm due to negligence (date of knowledge) or 3 years from the date of a person’s death. Where death has occurred, the claim can be brought on behalf of the person’s estate. In the case of minors, the 3 year limitation period starts running once they have reached the age of 18. For people who lack capacity to litigate, limitation does not run.

Where limitation has expired, a moratorium on limitation can be agreed between the parties for example where there has been a genuine difficulty obtaining records or expert reports or where the claimant has been ill. If a moratorium cannot be agreed, a Claimant can make an application to court to have limitation set aside and would have to satisfy a judge that the failure to bring the action within the 3 years is justifiable and there would be no prejudice to the Defendant’s investigation of the claim if limitation were to be set aside.

Litigation is lengthy and expensive.

Policy statement

This document sets out the Health Board's policy for the management of clinical negligence claims, personal injury claims and PTR matters brought against the Health Board.

Scope

The scope of this policy covers all staff employed by Hywel Dda University Health Board who are involved in a claim or redress matter.

Aim

The aim of this policy is to assist staff to understand the claims and redress processes and support them in assisting the health board when a claim is brought against it or when a case is being managed under redress.

Objectives

The aim of this document will be achieved by the following objectives:

- To assist those employed by the Health Board to adopt a standardised approach when dealing with claims and redress.
- To provide an understanding of why it is necessary to gather evidence quickly and make a concerted effort to bring the claim/redress matter to a swift conclusion.
- To ensure that the relevant Pre-Action Protocols/ PTR regulations are followed.
- To provide an understanding of why claims are sometimes settled without making any admissions to save on the cost of litigation where there is a litigation risk.
- To explain what alternative dispute resolution (ADR) is and why the Health Board might engage in that process.

Managing Claims Procedure

A clinical negligence claim is usually brought against the Health Board rather than an individual member of staff as the Health Board takes responsibility for the actions/inactions of all of its "servants and agents." This is known as vicarious liability.

Where an employee has not followed policy or has directly operated against policy then, following legal advice, it may be necessary for an individual member of staff to become the Defendant or Co-Defendant in a matter which means they would become a party to the proceedings allowing them to have their own legal representation in court. This rarely happens but remains a possibility.

The Health Board is initially notified of a potential claim by way of a request for copies of the Claimant's medical records and, when the records have been disclosed and reviewed by the Claimant's solicitors, where the claim is being pursued, a Letter Before Action or a Letter of Claim will follow setting out the allegations of negligence being brought against the Health Board and the harm alleged to have been caused. The Health Board has 4 months to prepare a letter of response in clinical negligence matters and 3 months in personal injury claims.

Once the Health Board is notified that a claim is being pursued, solicitors at Legal and Risk Services (L&RS) are instructed to act on its behalf in all clinical negligence and personal injury claims. The Claimant's medical records are provided to the solicitor at L&RS who, at that stage, will review the matter, request witness comments/statements, policy documents and any other relevant documents. In the case of personal injury claims, other documents might be required such as plans, maintenance records etc...

The relevant staff will be asked to prepare a factual witness statement setting out their involvement in the patient's care. Staff involved in a claim should not discuss their evidence with any other staff member involved with the same claim nor allow others to read their witness statements. If they need support it should be sought from a manager not involved in the claim who could be their line manager if they are not a witness or a different manager within the directorate if they are.

Independent expert witnesses are usually instructed to provide an opinion on whether there has been any breach of duty of care, whether or not any harm was caused due to that breach (causation) and, if so, the extent of that harm and future prognosis (condition and prognosis). The experts should be like for like in relation to breach of duty, however, other experts such as Occupational Therapy (OT), Physiotherapists or care experts may be necessary to give an opinion on causation, condition and prognosis. Once staff have completed their factual statements, they will have an opportunity to read and make comments on the expert reports and, where appropriate, assist the legal team in formulating questions to be put to the expert witnesses.

After all of the evidence is obtained, the solicitor at L&RS will advise the Health Board on whether there is enough evidence at that stage to defend the claim or whether the Health Board should concede liability in full or in part. A further review on liability will take place after the parties exchange witness evidence and expert reports. In appropriate matters, the expert witnesses will meet to produce a joint statement to establish what points can be agreed and whether they can narrow down any outstanding issues between them. Counsel will be instructed to advise in more complex matters.

When a decision has been made to settle a claim, the Health Board has 60 working days to produce a Learning from Events Report (LfER – [Appendix A](#)) showing what has been done to mitigate against the risk of the same issue recurring. Evidence of any actions taken such as minutes of meetings, audits and distribution lists must accompany the LfER otherwise reimbursement may be deferred until the Health Board can produce the evidence. The service(s) must also provide a Learning Assurance Plan (i.e. Audits, regular scrutiny meetings etc) to show that the actions put in place have been sufficient to mitigate against the risk of recurrence. If the evidence cannot be produced, the Welsh Risk Pool (WRP) may decline reimbursement. This would have serious financial consequences for the health board if the value of the claim is high. It can also result in an increase in the amount of money the Health Board has to contribute to the WRP at the start of the financial year and may affect reimbursement of cases of a similar nature.

At times, it may appear possible at the outset to defend a claim, however, as the matter progresses, if it becomes evident that there are likely to be significant risks in taking the matter to trial, The Health Board may be advised by the solicitor/counsel to settle the matter on an economic basis without making any admissions. This will avoid incurring unnecessary litigation costs which can be significant. In smaller claims, the costs can be greater than the damages awarded

If the matter progresses to trial, some or all of the staff members involved will be called to give oral evidence. Prior to the trial date, counsel for the Health Board will meet with the witnesses to help them prepare for appearing in court. Those witnesses will also have access to their line manager or other manager for support who can attend court with them.

The witnesses will receive a court summons. Once they have been served with a summons they must attend court on the specific day they have been asked to attend. Failure to do so without good reason would render the witness in contempt of court which can have significant consequences for them individually (a fine or imprisonment depending upon the circumstances). If a witness receives a summons and cannot attend on the day for good reason, they should inform the court directly **and** the Legal Services manager as soon as possible to avoid any adverse consequences.

Where appropriate, LRS may advise alternative methods of resolving disputes such as Mediation (the mediator helps both sides to reach agreement between themselves) or Alternative Dispute Resolution other ways of reaching agreement without going to court. If that happens, authorisation to settle by mediation/ADR is sought from a member of the Executive Board prior to Mediation/ADR (see [Appendix B](#), Schedule of Delegation). Accompanying the authorisation form for signing by the executive will be counsel's assessment of quantum and advice on a settlement figure. In the event new information comes to light during mediation causing Counsel to change their advice in relation to settlement, in order to avoid missing an opportunity to conclude the case, delegated authority is given to the Legal Services Manager and the legal representatives to act in the Health Board's best interests and a written explanation will be provided to the Chief Executive thereafter. Witnesses will not be asked to attend mediation or a joint settlement meeting.

At the end of a matter, the Claims Managers have to submit a Case Management Report (see [Appendix C](#)) and U2 checklist within 4 months of the final payment being made giving an outline of what has happened and how the Claim was managed. This is submitted to the WRP for reimbursement. Reimbursement can also be applied for during the course of a claim when the expenditure reaches £100,000.

In a claim where the recipient of the damages award is a child or an adult who lacks capacity to instruct a solicitor in relation to the proposed settlement figure, an approval hearing will take place in which a judge will determine whether the settlement agreed between the parties is fair and should be approved.

L&RS can also provide general legal advice in areas such as judicial review, data protection, funding, procurement, contracts, employment and property etc... The Health Board may also request general legal advice from solicitors/barristers other than those in LRS where specialist legal advice is required.

This policy does not cover **small claims** and **claims which to not have a personal injury element to them** such as those involving road traffic collisions, damage to property. Claims such as these are covered by a different policy, the link to which can be found below:

https://nhswales365.sharepoint.com/sites/HDD_Corporate_Governance/Policies/Forms/AllItems.aspx?id=%2Fsites%2FHDD%5FCorporate%5FGovernance%2FPolicies%2FFinancial%20Procedures%2F066%2F066%20%2D%20Losses%20and%20Special%20Payments%20Procedure%2Ev3%2Epdf&parent=%2Fsites%2FHDD%5FCorporate%5FGovernance%2FPolicies%2FFinancial%20Procedures%2F066

Redress

The investigation of a matter under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 is conducted in two stages. Firstly, the concern will be investigated by the Feedback team or Quality Assurance Team under Part 5 of the Regulations (Handling of a Concern). Secondly, where it is found under Part 5 that there has been a breach of duty of care which has or may have caused harm or loss, the matter will be referred to the Redress Team who will continue to progress the matter under part 6 of the regulations (Redress). During an investigation under part 5, the Feedback or QAST team may seek the advice of the Redress and Legal Services Managers in relation to breach of duty or to ask them to instruct an expert for an independent opinion on whether or not there has been a breach of duty of care. In this instance the expert will be instructed by the Health Board alone.

Once it is established that a qualifying liability may or does exist, the Redress team will assess what, if any, harm or loss has been caused by the breach of duty(causation), and, where established, the extent of the harm or loss. Under Part 6 of the Regulations, an independent expert may be instructed on a joint basis to determine causation. Once the expert has been agreed by both parties, he/she will be instructed on a joint basis to provide a causation report or causation, condition and prognosis report.

Where a Qualifying Liability is admitted the appropriate type of redress will be considered and an offer of redress will be made to the complainant either directly or via their legal team if instructed. Redress can take a number of forms including an apology; remedial treatment, financial compensation or a combination of any of those. If financial compensation is appropriate, the matter will be quantified by the Redress and Legal Services Manager with assistance from Deputy/Head of Legal Services or the solicitors at L&RS in the more complicated matters and an offer made to the patient. If an award is being considered above £25,000 in damages (general and special combined) and/or there is a Compensation Recovery Unit (CRU) certificate or NHS Certificate from Department of Work and Pensions (DWP) over £3,000, approval must be sought from L&RS solicitors **prior** to the offer being made (see WRPS Reimbursement Procedures (2019) 21.0-5 and 22.0-22.7).

To ensure a level playing field, the person raising the concern is entitled to instruct a solicitor to advise them on causation, the value of the claim and consideration of any offer of redress made by the Health Board. Under Part 6 of the Arrangements the costs of a solicitor will be met by the Health Board in accordance with Appendix O of the Putting Things Right document, the 'Fixed Fees Framework.'

In a matter settled under the Regulations, where the recipient of the damages award is a child or an adult who lacks capacity to instruct a solicitor in relation to the proposed settlement figure (Reg 33(f)(i)(ii)), either a Parental Indemnity Waiver Agreement can be signed by a parent with parental responsibility in the case of a child or, in respect of an adult, a Lasting Power of Attorney/Court Appointed Deputy for property and affairs can sign a Waiver Agreement. If none of the above are available to sign the Waiver Indemnity/Agreement, it will be necessary for an application to be made to court for a judge to determine whether the proposed settlement agreed between the parties is fair and should be approved.

At the time a qualifying liability is admitted, the Redress Team has 60 working days to submit a Learning from Events Form which has to be completed by the service. Any issues in the case must be

identified on the form together with actions taken to minimise the risk of the same issues recurring in future. Documentation to evidence such actions (i.e. minutes of meetings, training sessions with attendee list, audits and distribution lists where memos have been produced etc.) must also be submitted with the LfE. The service(s) must also provide a Learning Assurance Plan (i.e. Audits, regular scrutiny meetings etc.) to show that the actions put in place have been sufficient to mitigate against the risk of recurrence. Failure to provide an LfE on time, may result in the Health Board not being reimbursed, an increase in the amount of money the Health Board has to contribute to the Welsh Risk Pool at the commencement of the financial year and it may affect reimbursement of future cases of a similar nature. The LfER from for claims and redress can be found at [Appendix A](#)

If a case has settled at or below £25,000 under the Redress process or above £25,000 by the Redress team 'in the spirit of the PTR Regulations' (but outside of the regulations, see PTR Regulation 29.3 and WRPS Reimbursement Procedures (2019) 21.0-5) or a redress matter discontinues and the matter progresses as a claim, a Case Management Report (see [Appendix D](#)) and U2 Checklist are to be submitted to WRP within 4 months of the final payment made on the case or the case being transferred to a different route.

At 12pm on the last working day of each quarter the Health Board will submit to WRP the three 'Forecast' spreadsheets detailing each and every 'open' redress case, identifying the stage of the case, predicted forecast of damages/costs for each case and detailing the payments made to date on each case (see WRPS Reimbursement Procedures (2019) at 28.0)

The Redress Team will submit figures for the Welsh Government Pro Forma to WRP for the previous quarter in the first month of the quarter.

Where a claim is initially being pursued, if it fits the criteria for consideration under PTR, the Claimant will be asked whether they want to change to the PTR pathway. It is up to the Claimant to decide how they would like to proceed.

In accordance with Putting Things Right Regulations 14(1)(i) - if court proceedings are issued when a concern/complaint is under investigation or has passed to the redress team, all further investigations of the concern and/or redress must stop and the matter will progress in accordance with the Civil Procedure Rules.

Claims involving GP Practices

For General Medical Practices, in relation to incidents occurring on or after 1 April 2019, the Health Board can provide an indemnity arrangement and will be the named Defendant for clinical negligence litigation. LRS GMPI Team will act on behalf of and seek instructions from the Health Boards in relation to the litigation and will seek evidence and views on strategy from General Medical Practices and their staff.

Matters will be sent to L&RS for triage to GMPI@wales.nhs.uk to see if it is in scope for the GMPI scheme.

On conclusion of a case LRS will co-ordinate the Learning from Events Report and Case Management Report in liaison with the Redress and Legal Services Manager for submission to the WRP.

Confidentiality and Disclosure

During a claim or PTR matter, the Health Board will be asked, on production of a consent form, to disclose the patient's medical records to the Claimant's legal representatives. This will include **any document** where information has been stored about a patient in either written or electronic form. Full disclosure of all information is essential in order for both sides to be in a position to fully assess their positions during the course of a claim. Late disclosure of documents available at the outset of a claim can jeopardise the Health Board's ability to defend a matter. When staff are notified of a claim they will need to inform the Redress and Legal Services Manager or all places where information is stored as this may differ from directorate to directorate. Examples of the types of documents for disclosure can be found at [Appendix E](#).

Disclosure will be made in accordance with the Health Board's Information Governance Policies and Procedures redaction may be required prior to disclosure, for example, where there are allegations made about a 3rd party or there are other 3rd party references in the records.

Information gathered during the course of a claim will be stored in accordance with the Health Board's Information Policies and Procedure for Records Management, Data Protection and Confidentiality.

Correspondence with the directorate relating to a claim should **never be stored** within the patient's medical records, nor should any legal advice obtained for any purpose. Legal advice attracts Legal Professional Privilege (LPP) and, as such, should not be disclosed to any other party in the proceedings. If the information becomes part of the medical records it will be disclosed within the record any legal advice in the file should be redacted and an exemption applied. Legal matters should be stored in a separate file. It may sometimes be necessary to file a Court Order within the medical records but staff will be advised if this is necessary.

Financial Matters

Welsh Government (WG) has delegated the responsibility to authorise the settling of claim up to a limit of £1,000,000 to the Chief Executive/UHB. Any claims over this amount which have not been managed in accordance with the relevant legal framework will be treated as losses which will require either retrospective approval from WG (if appropriate) or recover/write off action. For claims over £1,000,000 authorisation to settle has to be sought from the Welsh Government. Legal and Risk Services obtain such authorisation directly on behalf of Health Boards once authority from the CEO has been obtained.

Legal Services Managers and relevant finance officers will maintain the databases for all claims and redress management including appropriate accounting provision for the Health Board liabilities. All payments in respect of clinical negligence or personal injury claims will be entered in the register of losses and special payments LaSPAR by the Finance Department.

The Health Board agrees delegated financial limits for the settlement of each claim as set out in [Appendix B](#)

Links between Concerns, Risk and Litigation

Adverse incidents or outcomes where the severity of the incident is severe or catastrophic and which could lead to a claim for negligence should be identified and reported to the Head/Deputy Head of

Legal Services when they occur, either by provision of an incident report or by provision of the required information such as:-

- a. Details of potential patient/staff member/visitor
- b. Date and details of incident/outcome from which a claim might arise
- c. Names of clinical, nursing and other staff involved in or witnessing the incident
- d. Statements by clinical, nursing and other staff involved in or witnessing the incident.

Whether a potential claim has previously been reported as an incident or concern can be identified within the Datix system. This assists with expediting the process of gathering information.

Reports providing information on concerns, claims and risks will be provided to relevant groups to enable information to be cascaded through all levels of the organisation.

Early Reporting Scheme - potential claims involving hypoxic brain injuries following birth.

The early reporting scheme devised by L&RS is currently under review. The previous pathway was found to be too onerous with no real benefit when it came to investigating the claim. It is to be simplified by L&RS with a change in the criteria for referral. Health Boards are to be informed of the new process in due course.

Learning Lessons

All directorates and services within the UHB are required to have systems in place for identifying issues as they arise and for putting actions in place to minimise the risk of or prevent similar occurrences. This is done through the incident reporting module on the Datix system. Through the system's incident reporting function, local trends can be identified highlighting where remedial action is required. Monitoring the efficacy of changes will involve the Clinical Audit Department. Each Directorate has responsibility for ensuring that any identified and agreed actions are implemented and monitored and that lessons are shared across the organisation.

Any new risks identified through the investigation of a claim must be subject to a full risk assessment carried out by the relevant service and incorporated within the relevant risk register

The Learning Lessons Sub-Committee (LLSC) will meet regularly to consider themes and trends and specific cases. Making suggestions and authorising proposed changes where issues have been identified during the investigation of incidents/concerns/claims necessitating a change in process, pathway or practice. Appropriate seniority level will represent directorates at this meeting in order to facilitate decision making and/or effect change. The findings/decisions made at LLSC will be reported to the Quality, Safety, Experience and Assurance Committee (QSEAC) meetings at board level.

Novel, Contentious or Repercussive Matters

Settlements within the UHB delegated limit of £1 million will not usually be reported to the WG. However, any claims which exceed the UHB delegated limit of £1 million or that are novel, contentious or repercussive will be reported to the WG via the Delivery Unit for approval. These will include claims, which could set an unintended precedent.

Audit

The responsibility for auditing compliance with this policy and procedure lies with the Director of Nursing, Quality and Patient Experience. The Legal Services Team will ensure an audit is carried out which complies with the WRP Concerns and Compensation Claims Management Standard.

Responsibilities

Chief Executive

The Chief Executive has overall responsibility for the management of legal claims made against the Health Board which is delegated to the Director of Nursing, Quality and Patient Experience. The Chief Executive (or other Executive Office holder) is also responsible for signing the Case Management Report at the conclusion of a matter for Reimbursement by the WRP in Claims. Any risks identified as a result of claims will be fed into the appropriate Risk Register by the service.

Director of Nursing, Quality and Patient Experience

The Director of Nursing, Quality and Patient Experience is the designated Director responsible for legal issues and claims relating to clinical negligence, personal injury, property and other relevant losses and for keeping the Health Board informed of major issues or developments affecting the organisation. The Director also has responsibility for recommending, agreeing and implementing a reporting mechanism to facilitate monitoring of claims. This should include an annual review of claims management, in accordance with the WRP Concerns and Compensation Claims Management Standard Assessment Standard.

A request for compensation following on from a concern can be made by the patient. The Director of Nursing, Quality and Patient Experience can authorise payments in line with the Redress scheme, without legal advice, for sums within the authorised limit, see [Appendix A](#). The Director will establish structures to ensure:-

- a. Staff responsible for handling claims act within their delegated limits and levels of authority
- b. Claims are investigated thoroughly, speedily and accurately with appropriate internal and independent overview
- c. Legal and expert advice is obtained when necessary and such services deliver the best value for money
- d. The outlay in damages and costs reflects the best settlement possible for the Health Board, see [Appendix A](#).
- e. Processes to learn lessons from claims are adhered to and the implementation of agreed actions to improve safety is monitored by the relevant service
- f. Legal and Risk services provide regular reports on probabilities, estimated claims values and anticipated settlement dates
- g. Reports are submitted to the Listening and Learning Sub-Committee on a themed basis, a sub-group of the Statutory Quality, Safety and Experience Assurance Committee
- h. The Datix Database is maintained
- i. There is an annual audit of cases submitted for reimbursement to the WRP as required by WRP Standard 5.

All Executive Directors

All Executive Directors have a delegated accountability and responsibility within their directorates for the implementation of and adherence to this policy and to ensure that any failings identified within the directorates are addressed as soon as is practicable and any lessons learned are shared across the organisation.

Medical Director

The Medical Director has responsibility for ensuring that any failings identified during the investigation of a claim are addressed appropriately. Any issues of a medical nature that the team are struggling to address can be escalated to the medical director if cannot be resolved by another means. The Medical Director will be supported in this by the Director of Operations /Deputy Chief Executive.

Heads of Service and Directorate/Hospital Senior Management Teams

Heads of service and directorate/hospital senior management teams are responsible for ensuring the policy is distributed to and read by members of their teams and that the policy is understood and adhered to. Heads of service and senior managers will be responsible for ensuring that witness evidence and policy documents are provided in a timely manner when requested and ensuring that actions are taken to remediate any identified failings which arose during the investigation of a claim or redress matter. They are responsible for producing and monitoring action plans, providing evidence of actions taken to address issues identified and evidence of how the learning has been cascaded throughout the organisation. They are responsible for providing this evidence in accordance with the timescale for submitting the LfE report to the WRP.

Assistant Director (Patient Experience/Legal Services) and the Redress & Legal Services Managers

The Assistant Director (Patient Experience/Legal Services) is responsible for producing the policy for claims management and ensuring this is being implemented across the organisation.

The Assistant Director (Patient Experience/Legal Services) and the Legal Services Team are responsible for:

- a. The management of claims
- b. Facilitating compliance with this policy
- c. Facilitating compliance with the All Wales Putting Things Right Guidance in respect of Part 6 of the regulations
- d. Complying with delegated authority limits
- e. Securing the most cost-effective resolution of claims.

The Health Board will ensure that the appointed Legal Services Managers have sufficient seniority as required by the WRP standard 5 - Concerns and Compensation Claims Management.

Managers and Staff involved with claims

Managers and Staff involved in a claim must provide evidence when requested to do so in accordance with the code of practice from their relevant regulatory bodies. They will be kept informed of the progress and outcome of individual cases by the Redress and Legal Services Manager with conduct of their particular claim.

Legal Services Team

Legal Services Team will support directors, service managers and staff in this process by:

- a. Helping staff to understand the process
- b. Providing assistance with identifying the issues in a claim
- c. Assisting with the preparation of witness statements
- d. Supporting staff if the matter goes to trial.

The Redress and Legal Services Managers:-

- a. Have Responsibility for updating the Datix system for claims and redress matters as they progress.
- b. Are responsible for reviewing the LfE and advising on its contents.
- c. Are responsible for submitting the WRP documentation completed by the directorate
- d. Will ensure that any requests from the WRP for further information on a form WRP8 will be conveyed to the directorate promptly in order for the information to be gathered swiftly by the directorate for submission to the WRP within the timescales set.
- e. Will provide routine reports to UHB appropriate committees.
- f. Will be suitably experienced and qualified, either on appointment or be working towards a suitably recognised qualification in claims management.
- g. Will be supported by the UHB in continuing professional development and have sufficient standing within the organisation to demonstrate seniority and status fit to exercise direct access to the relevant Directors as appropriate
- h. Will be kept up to date with Wales Wide issues by attending the WRP Claims and Redress Networks meetings – Claims Specialist Sub Group, the Listening and Learning Sub Committee and WRP and L&RS conferences. The Redress and Legal Services Managers should make every effort to attend and feed back to appropriate staff, managers and /or committee(s).
- i. Will inform the WRP of any claims where the alleged negligence occurred during the period covered by the former Dyfed Powys Health Authority. These claims predate the merger of the Trusts to form the Hywel Dda UHB and are managed in accordance with the guidance provided by the WRP. LRS should also be informed to ensure the claim is allocated to the correct defendant on the quantum listing.
- j. Will be responsible, following legal advice, for authorising settlement of reasonable costs.
- k. Will identify and manage claims on the Ministry of Justice Personal Injury Claims Portal as a means of reducing legal costs and speeding up the process.
- l. Will identify any claims over £1,000,000, any nuisance, contentious or recurring claims and seek legal advice from L&RS who will, if appropriate, inform WG.
- m. Will implement a quarterly review process to include the updating of information in Datix from information in the quarterly quantum listing supplied by L&RS.
- n. Will be made aware of concerns or incidents that may become claims with a view to resolving issues with complainants or litigants in person prior to litigation.
- o. Will arrange training in the application of the Claims Management Policy and any identified legal training needs.
- p. Will, on advice, consider the use of Alternative Dispute Resolution.
- q. Will follow the All Wales Putting Things Right Process to mitigate against the risk of a complaint escalating into a claim.
- r. Will, where appropriate, offer PTR to a Claimant as an alternative route, where a Letter of Claim has been received. It will be for the Claimant to decide whether to change the pathway or continue with the matter as a claim.

- s. Receive potential claims and, where appropriate, will inform the directorate for example where there is a linked incident or complaint. Once a letter before action or letter of notification arrives, the matter will be referred to L&RS.

All members of staff

All members of staff must report all adverse incidents in line with the Health Board's incident reporting policy, including those that may lead to claims for compensation.

All staff are required to fully and openly co-operate with the investigation of any legal claims and to comply with this Policy and their regulatory code of practice. This duty continues even after they have left the organisation.

Unless there are exceptional circumstances, Health Board staff are expected to provide a witness statement when asked to do so. Support and guidance will be provided to members of staff who are asked to give written evidence /attend court.

The Health Board will take responsibility for managing and, where appropriate, settling claims and meeting all financial obligations relating to a claim save where, in very exceptional cases, the health professional was found to be acting outside of his/her remit. In such circumstances the member of staff may be advised to obtain separate legal advice to avoid any conflict of interest.

The Listening and Learning Sub Committee

Approval of this Claims Management Policy has been delegated to the Business Planning, Performance and Assurance Committee and the arrangements for complying with this policy will be delegated to the Listening and Learning Sub Committee which is a sub-group of the Quality, Safety and Experience Assurance Committee.

The Welsh Government and the Welsh Risk Pool

The WG funds the WRP by a top slicing arrangement. The WRP reimburses all claims in excess of £25,000, and Redress cases both under and over £25,000, as long as the Health Board is compliant with the WRP reimbursement procedure.

Where the Health Board is unable to comply with the WRP reimbursement pathway, for example by not providing information in accordance with the WRP deadlines, there is a risk that reimbursement will not take place and/or the amount top sliced against the Health Board may be increased.

Legal Advisers

The Health Board instructs Legal and Risk Services to advise in confirmed clinical negligence and personal injury claims on:

- a. Breach of Duty and causation (liability)
- b. The merits of a claim
- c. The strength of the defence and the probability of success or otherwise
- d. The likely valuation of a claim best and worse scenarios and on negotiating settlement;
- e. An estimate of legal costs for claimant and defendant.

In complex matters or where a matter is taken to trial a barrister will be instructed by Legal and Risk Services to advise and represent the Health Board in court.

The Health Board Responsibilities

The Board of the Health Board is accountable for the performance of the organisation, in handling claims and ensuring that improvements are made where issues with care become apparent. It is responsible for monitoring claims/redress matters and ensuring that any themes and trends are addressed to avoid similar issues occurring in future.

The Health Board is responsible for supporting staff who are asked to assist with claims and redress matters to facilitate frank and open discussion in accordance with the pending statutory duty of candour.

Delegated authority for medium and low cost claims has been agreed as set out in [Appendix A](#) of this policy which complies with the Standing Financial Instructions.

Training

Training on Claims Management is provided to clinical and non-clinical staff on a regular basis. This is also undertaken in line with the training on Putting Things Right and Being Open processes.

Implementation

This process will be implemented by the Legal Services Managers.

Relevant Documents

This policy complies with the following documents:

- The Civil Procedure Rules 1998
- All Wales Putting Things Right Guidance
- The WRP Concerns and Compensation Claims Management (2013)
- The WRP Reimbursement Procedure, Guidance on Electronic claims' submission and other Procedures
- The UHB's Standing Orders and Standing Financial Instructions
- WRP All Wales Policy on Insurance, NHS Indemnity and related risk management for potential losses and special payments (2020)
- The National Health Service (Concerns, Complaints and Redress Arrangements (Wales) 2011
- GMPI Guidance from Legal and Risk Services

Appendix A – Learning from Events Reports – Clinical

<h1>Learning from Events Report</h1> <h2>Report on Learning following investigation</h2>		
Checklist S1C v2.4		
LFER Report Submission to:	NHS Wales Delivery Unit	
Mark the appropriate recipient of the LFER with an 'X'	Welsh Risk Pool Safety & Learning Team	
Name of Health Body		
Health Body Case Reference		
Nationally Reported Incident Reference Reference number provided by the NHS Wales Delivery Unit		
Welsh Risk Pool Case Reference Reference number provided by the Welsh Risk Pool		
COVID-19		
Is this case related to arrangements, care or processes for COVID-19? See Welsh Government Technical Advice Group and IMTP Planning Framework definitions: https://gov.wales/technical-advisory-group-5-harms-arising-covid-19 https://gov.wales/sites/default/files/publications/2021-11/nhs-wales-planning-framework-2022-to-2025-impact-assessment.pdf		YES / NO
Analysis of the Five Harms of COVID-19	Harm from Covid itself	
	Harm from an overwhelmed NHS and social care system	
	Harm from reduced non-Covid activity	
	Harm from wider societal actions / lockdown etc	
	Harms related to new or existing inequalities -directly/ indirectly from Covid-19	
CLINICAL NEGLIGENCE CASES		
This section is only applicable for matters submitted to the Welsh Risk Pool		
Is this case linked to a clinical negligence claim or redress matter handled under the PTR Regs?		YES / NO
Date of decision to settle case		
Trigger for decision to settle case	Redress QL determined	
	Decision to make admissions	
	Decision to make offer	
	Decision to accept offer	
	Damages awarded at trial	
	Other	
>£1m Case?	Is the case definitely or likely to exceed £1m in value, where Welsh Government approval is required to settle the matter?	YES / NO
SAFETY COMPLIANCE		
Is this case considered to be a NEVER EVENT		YES / NO
Is this case associated with non-compliance with a Patient Safety Alert or Notice		YES / NO
RECURRING THEME		
Does the Health Body consider that this event is caused by a common or recurring root cause? If YES please provide details		YES / NO

Learning from Events Report

Report on Learning following investigation

Checklist S1C v2.4

CONTENTS

- 01.00 Case Summary
- 02.00 Investigation Approach
- 03.00 Harm or outcome arising from the event
- 04.00 Additional or incidental findings
- 05.00 Issues & Actions
- 06.00 Learning Assurance Plans
- 07.00 Being Open / Duty of Candour
- 08.00 Sharing of Learning & Improvement
- 09.00 Supporting documentation
- 10.00 Categorisation/Thematic Review
- 11.00 Learning from Events Declarations
 - Checklist & Guide for Completion

Submission Arrangements

LFERs relating to Nationally Reportable Incidents are submitted to the NHS Wales Delivery Unit via email:

NationalSIreports@wales.nhs.uk

LFERs relating to Clinical Negligence Claims or Redress Cases are submitted to the Welsh Risk Pool via email: WRPS.ClaimsReimbursement@wales.nhs.uk

1.00 Case Summary

1.01

2.00 Investigation Approach

2.01

3.00 Harm or outcome arising from the event

3.01

4.00 Additional or incidental findings

4.01

5.00 Issues & Actions

Issue	Actions	Status
	REF	

Issue	Actions	Status
	REF	
	REF	

6.00 Learning Assurance Plans

Ref	Topic	Plan Summary	Status

7.00 Being Open / Duty of Candour

7.01

8.00 Sharing of Learning & Improvement

8.01	
Key Messages for National Sharing	<i>What are the key messages from this case for sharing with other NHS Organisations?</i>

9.00 Supporting Documentation

Ref	Title	Outline

10.00 Categorisation / Thematic Review

National organisations are monitoring themes and trends associated with the issues that arise within events that are the subject of learning reports. Please flag any of the categories which directly or indirectly relate to the issues identified in this case.
NB The categories are intentionally broad to enable further analysis of the case by specialist teams.

Category / Theme	Related to this case? <i>Mark any that are related with a X</i>		
Maternity Services			
CTG Interpretation			
Radiology Images			
Consent to Examination or Treatment			
VTE Management			
Delay to Treatment / Lost to Follow-up			
DEATH OF PERSON AFFECTED			
Does this case relate to a patient who has died?	YES / NO		
Cause of death			
Inquest status	<input type="checkbox"/> Inquest scheduled (specify date): <input type="checkbox"/> Inquest taken place (specify date): <input type="checkbox"/> Coroner has decided not to open an inquest <input type="checkbox"/> Pending Coroner's decision to open an inquest		
Coroner's Conclusion <i>If relevant and available, please provide full details of the Coroner's conclusion</i>	<table border="0"> <tr> <td> <input type="checkbox"/> Natural causes <input type="checkbox"/> Accidental Death <input type="checkbox"/> Unlawful Lawful killing <input type="checkbox"/> Alcohol / Drugs related <input type="checkbox"/> Narrative <i>(provide details)</i> </td> <td> <input type="checkbox"/> Industrial Disease <input type="checkbox"/> Road Traffic Collision <input type="checkbox"/> Open <input type="checkbox"/> Suicide </td> </tr> </table>	<input type="checkbox"/> Natural causes <input type="checkbox"/> Accidental Death <input type="checkbox"/> Unlawful Lawful killing <input type="checkbox"/> Alcohol / Drugs related <input type="checkbox"/> Narrative <i>(provide details)</i>	<input type="checkbox"/> Industrial Disease <input type="checkbox"/> Road Traffic Collision <input type="checkbox"/> Open <input type="checkbox"/> Suicide
<input type="checkbox"/> Natural causes <input type="checkbox"/> Accidental Death <input type="checkbox"/> Unlawful Lawful killing <input type="checkbox"/> Alcohol / Drugs related <input type="checkbox"/> Narrative <i>(provide details)</i>	<input type="checkbox"/> Industrial Disease <input type="checkbox"/> Road Traffic Collision <input type="checkbox"/> Open <input type="checkbox"/> Suicide		

Was a Regulation 28 issued by the Coroner?	<input type="checkbox"/> Inquest not yet held <input type="checkbox"/> Inquest held but a Regulation 28 was not issued <input type="checkbox"/> Yes, a Regulation 28 was issued <i>(please provide details):</i>
--	---

11.00 Learning from Events Declarations

GOVERNANCE LEAD DECLARATION
<i>To be signed in all submissions to the Welsh Risk Pool</i>
I have considered fully the investigation findings, issues, actions plans and learning assurance, and confirm that the details recorded above are complete, accurate and reasonable response to the findings of the case.
Signed by
Date:
Print Name –
Position –

LEGAL CASE MANAGER'S DECLARATION
<i>To be signed by the Claims Handler or Redress Case Handler for all submissions to the Welsh Risk Pool</i>
I have considered fully the management of this claim and my findings are recorded. I confirm that the details recorded in each relevant section are complete and accurate and that these aspects of the appropriate scheme guidance have been properly considered and actioned.
Signed by
Date:
Print Name –
Position –

EXECUTIVE'S DECLARATION
<i>To be signed by an Executive Officer for all National Reported Incidents</i>
I confirm that this incident has been thoroughly investigated and the findings and recommendations have been agreed by the appropriate committee and have either been acted upon or plans are in place to implement the actions within an agreed timescale.
Signed by
Date:
Print Name –
Position –

Checklist and Guide to Completion

The Learning from Events Report is used by Health Bodies in NHS Wales to report the issues that have been identified following investigation of a Nationally Reportable Incident or from a clinical claim or redress Investigation. The report also outlines how the identified issues have been addressed to reduce the risk of reoccurrence or reduce the impact of a future event. An alternative version of the document is available for use with non-clinical legal cases - including personal injury or violence & aggression matters.

Improvement to quality and safety in healthcare is aligned to learning which flows from case investigations, and the Learning from Events Report provides a framework for regulators and inspection bodies to gather assurance that appropriate improvement has been implemented. This version of the LFER document has been developed to facilitate use with reports made to the NHS Wales Delivery Unit as well as the Welsh Risk Pool.

It is important that the Learning from Events Report provides a sufficient explanation of the circumstances and background to the events which have led to the case, in order that colleagues who are scrutinising the report can identify the links to the findings and learning outcomes.

Supporting information, such as action plans, expert reports and review findings may be appended to the Learning from Events Report to evidence the learning activity. These should be referenced in the main document and the relevance of the attachments clearly outlined.

The Report must be signed by appropriate key staff within the organisation concerned. This will generally include senior staff within the service(s) involved who are required to take responsibility for ensuring actions and improvements are implemented.

For Claims and Redress Cases, the person responsible for coordinating the matter should also countersign the report (this is usually the claims handler).

For Nationally Reportable Incidents, an Executive Director must sign the declaration.

This checklist should be used to ensure that appropriate and relevant information is included in the report.

SUMMARY & REFERENCE SECTION

Submission of LFER to National Bodies

The organisation submitting the LFER should identify which national body the report is being submitted to.

Name of Health Body

The established Health Body needs to be identified. If the case relates to the services of a hosted or sub-contracted organisation, the relationship with the established health body must be outlined.

Case Reference Numbers

The local case reference number used by the organisation submitting the LFER should be provided. Additionally, the reference numbers provided by the NHS Wales Delivery Unit or the Welsh Risk Pool should be provided. LFER's may be returned if the appropriate reference number is not provided.

COVID-19 Cases

Please state YES or NO to identify if the case is related to the management of patients with coronavirus, contraction of infection or another matter related to the pandemic.

A breakdown of the five harms of COVID-19 is also required and all harms which apply to the case should be confirmed. The definitions relating to each harm from Covid are outlined by the Technical Advisory Group and each harm is specifically identified within the IMTP Planning Framework 2022-25.

Links to these documents are provided here

<https://gov.wales/technical-advisory-group-5-harms-arising-covid-19>

<https://gov.wales/sites/default/files/publications/2021-11/nhs-wales-planning-framework-2022-to-2025-impact-assessment.pdf>

A summary of the harms and the associated definitions is shown as follows:

	Planning Framework Title	Technical Advisory Group Definition
1	Harm from Covid itself	Harm directly arising from SARS-CoV2 infections;
2	Harm from an overwhelmed NHS and social care system	Indirect COVID-19 harms due to surge pressures on the health and social care system and changes to healthcare activity, such as cancellation or postponement of elective surgeries and other non-urgent treatments (e.g. harm from cessation of screening services) and delayed management of long-term conditions.
3	Harm from reduced non-Covid activity	Harms arising from population based health protection measures (e.g. lockdown) such as, educational harm, psychological harm and isolation from shielding and other measures.
4	Harm from wider societal actions / lockdown etc	Economic harms such as unemployment and reduced business income arising both from COVID-19 directly and population control measures, like lockdown.
5	Harms related to new or existing inequalities -directly/ indirectly from Covid-19	Harms arising from the way COVID-19 has exacerbated existing, or introduced new, inequalities in our society.

Details of the COVID-19 impact should be outlined within the case summary section.

Clinical Negligence Cases

For clinical negligence claims or redress cases handled under PTR regulations, specific information is required:

- *Decision to settle case*
The date of a decision by the health body to settle the case must be provided.
- *Trigger for settlement*
The date that the decision was reached by the Health Body to settle the matter must be recorded. For Redress matters, this is the date that a Qualifying Liability was determined. For clinical claims, this is

the date that a decision to make an offer, accept an offer, make admissions or award of damages at trial occurs.

- **Confirmation of >£1m case**

Where the case is definitely or likely to exceed £1m, and therefore require Welsh Government approval to settle the matter, this needs to be established in order that the Welsh Risk Pool can include the Welsh Government Healthcare Quality Team in the scrutiny process.

Safety Compliance

Details must be provided of whether the LFER relates to an incident or legal matter that is considered a Never Event or non-compliance with a Patient Safety Alert / Notice.

Recurring Theme

If there is considered to be a recurring causal theme, details should be outlined. It is important to note that this should relate to causal themes and not event themes. Examples of causal themes include 'omitted medication administration' or 'missing documentation'.

SECTION ONE Case Summary

A basic case summary of the circumstances of the events.

Remember to include the age and sex of the patient.

The name of the hospital or service and details of the unit, ward or team, on which the incident occurred should be included.

An outline of the relevant events relating to the case is required, and this should where possible be presented in chronological order.

Where appropriate, outline the long-term outcome – whether the patient died or they continue to experience ongoing symptoms or have fully recovered.

SECTION TWO Investigation Approach

Outline the approach to the investigation; include how the investigation is proportionate to the circumstances

Were there any linked or associated investigations or internal reviews (such as SI investigations, complaint investigations or inquest reports)?

What relevant internal comments were obtained?

What relevant external specialist comments were obtained?

For legal matters, outline the breaches of duty identified in the case, along with any causation issues.

SECTION THREE Harm or outcome arising from Event

What harm did the investigation findings identify?

Are there any outstanding issues relating to harm investigation?

SECTION FOUR Additional or incidental findings

Are there any incidental findings which are not related directly to the incident or case allegations?

SECTION FIVE Issues & Actions

What issues were highlighted from the investigation?

– such as failing in clinical care, errors in procedures and process or other breaches of duty?

What actions are being taken to reduce the likelihood of a reoccurrence?

What actions are being taken to reduce the impact of a repeat event?
How will the completion of the actions be measured (eg audit/ reports/ data)
For actions which are not yet complete, ensure clear timescales are provided.

SECTION SIX Learning Assurance Plans

What plans or reviews are in place to monitor the actions taken?
How will the Health Body monitor the quality of service or care provision?
How has the case been shared for wider learning?

SECTION SEVEN Being Open / Duty of Candour

How has the duty of being open been complied with?
Outline of communication with persons affected or advocates

SECTION EIGHT Sharing of Learning & Improvement Key Messages for National Sharing

Outline details of how learning from the case has, or is, being shared within the organisation.
Provide details of any national sharing of learning that has been carried out by the health body.

In addition to details of local and national sharing of learning that has been carried out, an outline should be provided of the key message that the health body feels should be shared nationally.
National bodies will collate and share key messages.

SECTION NINE Supporting Documentation

Name and outline of documentation appended to this report
It is usual practice to include supporting documentation as evidence of an action plan or action completion.

SECTION TEN Categorisation / Thematic Review

Flag any themes from the identified list.
The theme should be flagged if the case involves the category directly or indirectly.
If the case is associated with the death of a patient, details of involvement of HM Coroner must be outlined.

SECTION ELEVEN Learning from Events Declarations

For all cases submitted to the Welsh Risk Pool, the signature of Governance Lead(s) within services involved in the case is required. Where the matter relates to multiple teams / services / divisions, the signature section can be replicated for each signatory.

For legal claims or redress cases, the signature of the claims handler or redress case manager is required to comply with WRP Reimbursement Procedures.

For LFER's related to nationally reported incidents, the signature of an Executive Director is required.

Where a signature section is not required in a specific case, these can simply be deleted.

Learning from Events Report – Non Clinical Cases

- Personal Injury Claims - compensation agreed/awarded where payment of financial compensation has or may exceed £25,000
- Case exceeding £1m with Welsh Government approval required to agree damages

Report on Learning following investigation to the Welsh Risk Pool

Name of Health Body			
WRP Reference		Health Body Reference	
LASPAR Reference		L&R Reference	
WG SI Reference			

Is this case related to arrangements, care or processes related to COVID19?	YES / NO
---	----------

NON-CLINICAL NEGLIGENCE CASES			
Date of decision to settle case			
Trigger for decision to settle case		Decision to make admissions	
		Decision to make offer	
		Decision to accept offer	
		Damages awarded at trial	
		Other	
>£1m Case?	Is the case definitely or likely to exceed £1m in value, where Welsh Government approval is required to settle the matter?	YES / NO	
If Welsh Government approval is definitely or likely to be needed to settle the matter, the WRP team will include the Welsh Government Healthcare Quality Team in the scrutiny process of the report.			

- 1.00 Case Summary
- 2.00 Investigation Findings
- 3.00 Outcome of Event
- 4.00 Enforcement Authority Interventions
- 5.00 Issues & Actions
- 6.00 Learning Assurance Plans
- 7.00 Supporting documentation
- 8.00 Categorisation / Thematic Review
- 9.00 Declarations

1.00 Case Summary

1.01

2.00 Investigation Findings

2.01

3.00 Outcome of Event

3.01

4.00 Enforcement Authority Interventions

4.01

5.00 Issues & Actions

Issue	Actions		Status
	REF		

Issue	Actions		Status
	REF		
	REF		

6.00 Learning Assurance Plans

Ref	Topic	Plan Summary	Status

7.00 Supporting Documentation

Ref	Title	Outline

8.00 Categorisation / Thematic Review

The Welsh Risk Pool is monitoring themes and trends associated with the issues that arise within events that are the subject of learning reports. Please flag any of the categories which directly or indirectly relate to the issues identified in this case.

NB The categories are intentionally broad to enable further analysis of the case by specialist teams.

Category / Theme	Related to this case? <i>Mark any that are related with a X</i>
Manual Handling	
Violence & Aggression	
Sharps Management	
Slips / Trips / Falls	

9.00 Declarations

GOVERNANCE LEAD DECLARATION

I have considered fully the investigation findings, issues, actions plans and learning assurance, and confirm that the details recorded above are complete, accurate and reasonable response to the findings of the case.

Signed by _____ Date _____

Print Name –

Position –

CASE MANAGER'S DECLARATION

I have considered fully the management of this claim and my findings are recorded. I confirm that the details recorded in each relevant section are complete and accurate and that these aspects of the appropriate scheme guidance have been properly considered and actioned.

Signed by _____ Date _____

Print Name –

Position –

Appendix A – Learning from Events Reports – Non-Clinical

Learning from Events Report – Non Clinical Cases

- Personal Injury Claims - compensation agreed/awarded where payment of financial compensation has or may exceed £25,000
- Case exceeding £1m with Welsh Government approval required to agree damages

Checklist and Guide to Completion

The Learning from Events Report is used by Health Bodies in NHS Wales to report the issues that have been identified from a non-clinical claim and how these have been addressed to reduce the risk of reoccurrence or reduce the impact of a future event. An alternative version of the document is recommended for use with clinical cases.

Improvement to quality and safety in healthcare is aligned to learning which flows from case investigations, and the Learning from Events Report provides a framework for regulators and inspection bodies to gather assurance that appropriate improvement has been implemented.

The Learning from Events Report needs to provide a sufficient explanation of the circumstances and background to the events which have led to the case, in order that colleagues who are scrutinising the report can identify the links to the findings and learning outcomes.

This report can be used to capture the learning for non-clinical cases - including personal injury to staff, violence & aggression incidents to staff or other persons, damage or loss of equipment.

Supporting information, such as action plans, expert reports and review findings may be appended to the Learning from Events Report to evidence the learning activity. These should be referenced in the main document and the relevance of the attachments clearly outlined.

The Report must be signed by appropriate key staff within the organisation concerned. This will generally include senior staff within the service(s) involved - who are required to take responsibility for ensuring actions and improvements are implemented. The person responsible for coordinating the claim case should also countersign the report.

This checklist should be used to ensure that appropriate and relevant information is included in the report.

REFERENCE ID & SUMMARY SECTION

Name of Health Body

The established Health Body in the case needs to be identified.

Confirmation of >£1m case

Where the case is definitely or likely to exceed £1m, and therefore require Welsh Government approval to settle the matter, this needs to be established in order that the Welsh Risk Pool can include the Welsh Government Healthcare Quality Team in the scrutiny process.

Reference ID

WRP Reference

This information is used to track & link case & claimant data

Health Body Reference

LASPAR Reference

Decision to settle case

Date of decision to settle case

Trigger for settlement

The date that the decision was reached by the Health Body to settle the matter must be recorded. For Redress matters, this is the date that a Qualifying Liability was determined. For personal injury and other non-clinical negligence claims, this is the date that a decision to make an offer, accept an offer, make admissions or award of damages at trial occurs.

SECTION ONE Case Summary

What were the circumstances of the index event?

What were the substantive allegations of harm to persons?

What were the substantive allegations of loss of property or services?

SECTION TWO Investigation Findings

Were there any associated investigations or internal reviews (such as health & safety, fire safety or serious incident investigations)?

How was the case investigated?

What relevant internal comments were obtained?

What relevant external specialist comments were obtained?

What were the breaches of duty identified?

What were the causation issues identified?

SECTION THREE Outcome of the Event

What harm did the investigation findings identify occurred to a person?

Are there any outstanding issues relating to harm investigation (eg is there further assessments on condition & progress to be completed)?

Was there damage to property or equipment which required replace, replacement or other compensation?

SECTION FOUR Enforcement Agency Interventions

Was the event reportable to an enforcement agency (eg RIDDOR, HIW-IRMER)?

Were any investigations undertaken by the police?

Were there any investigations by the Health & Safety Executive?

Have there been any sanctions or interventions by an enforcement agency (eg Improvement Notice, Immediate Assurance Letter etc)?

Are any enforcement agency interventions ongoing?

SECTION FIVE Issues & Actions Taken

What issues were highlighted from the investigation?

– such as failing in clinical care, errors in procedures and process or other breaches of duty?

What actions are being taken to reduce the risk of a reoccurrence?

What actions are being taken to reduce the impact of a repeat event?

SECTION SIX Learning Assurance Plans

What plans or reviews are in place to monitor the actions taken?

How will the Health Body monitor safety standards in relation to this event?

How will the Health Body monitor the quality of service or care provision in relation to this event?

SECTION SEVEN Supporting Documentation

Name and outline of documentation appended to this report

SECTION EIGHT Categorisation / Thematic Review

Flag any themes from the identified list.

The theme should be flagged if the case involves the category directly or indirectly.

SECTION NINE Declarations

Signature of Case Handler within the responsible body

Signature of Governance Lead(s) within services involved in the case

If the actions taken require support or involvement of specialist services (such as Estates & Facilities) then a signature of the person responsible for these services in the Health Body is required.

In cases exceeding the delegated authority limit, the Learning from Events document does not require the signature of the Chief Executive – this is provided on the Case Management Report.

Appendix B – Table of Delegated Authority

The table below confirms levels of delegated authority.

Damages	Delegated authority
Over £1,000,000	No delegation. Refer to DU by L&RS
£100, 001 to £1,000,000	Chief Executive and Director of Finance
Up to £100,000	Chief Executive (or Deputy Chief Executive in absence of CEO) Director of Nursing, Quality and Patient Experience

NOTES:

1) Urgent decisions for the purpose of settling litigation claims

The Standing Financial Instructions, Appendix 7 of the Standing Orders paragraph 19.15 allow for the Chief Executive or nominated deputy in his absence, to provide such authorisation if appropriate.

2) Periodic payments

In cases over £250,000 (where the claimant is agreeable) the Chief Executive and Legal Services Manager, in conjunction with the UHB legal advisors and the WG will evaluate the cost and benefits of setting up periodical payments.

Appendix C – Case Management Report – CLAIMS

Checklist S21 v1.4

Case Management Report

Claim Managed under NHS Indemnity – Case Completed

Request to Welsh Risk Pool for reimbursement following payment of financial compensation exceeding £25k in relation to a clinical negligence claim

Name of Health Body	Hywel Dda University Health Board		
WRP Reference		Health Body Reference	HD/MN/
LASPAR Reference		L&R Reference	
WG SI Reference			

CASES MANAGED UNDER NHS INDEMNITY			
Has this case previously been managed under the Redress process?	YES / NO		
Is this case related to arrangements, care or processes related to COVID19?	NO		
Date of decision to settle case			
Trigger for decision to settle case	Decision to make admissions		
	Decision to make offer		
	Decision to accept offer		
	Damages awarded at trial		
	Other		
Date Damages Agreed			
Date Claimant's Costs Agreed			
Date of Financial Settlement (final payment being made in the case)			
>£1m Case?	Does the case require advance formal approval to make this special payment from the Welsh Government?	NO	
If Welsh Government approval is required, a copy of the authority to settle the matter MUST be included with this Case Management Report.			

- A Case Outline
- B Case Investigation
- C Quantum & Costs
- D Decisions & Governance

E Case Management Declarations

A Case Outline

A01

B Case Investigation

B01

C Quantum & Costs

C01

D Decisions & Governance

D01

E Case Management Declarations

CLAIMS MANAGER'S DECLARATION

I have considered fully the management of this claim and my findings are recorded. I confirm that the details recorded in each relevant section are complete and accurate and that these aspects of the PTR guidance have been properly considered and actioned.

Signed by Date _____

Print Name –

Position –

RESPONSIBLE BODY DECLARATION & AUTHORISATION

I confirm that the above details are complete and accurate, and all aspects of the checklist have been properly considered and actioned. I agree that this payment offers the best value for money.

I also confirm that:
(*please delete as applicable*)

- This case is within the delegated authority of this Responsible Body and is not novel, contentious or repercussive. I, therefore, agree to this special payment
- The Responsible Body has complied with its obligations and the conditions set out in Welsh Government Guidance to enable it to exercise its delegated authority to settle claims valued below £1 million
- This case requires advance formal approval to make this special payment from the Welsh Government and a copy of the approval is enclosed with this case management report

Signed by _____ Date _____

Print Name –

Position –

Signed by _____ Date _____

Print Name –

Position –

Please note that this section must be signed by 2 senior officers of the Responsible Body - both of whom must be authorised signatories and one of whom must be the Chief Executive in accordance with the delegated limits set by the Board

Case Management Report

Claim Managed under NHS Indemnity – Case Completed

Request to Welsh Risk Pool for reimbursement following payment of financial compensation exceeding £25k in relation to a clinical negligence claim

Checklist and Guide to Completion

For use with claims settled under NHS Indemnity

REFERENCE ID & SUMMARY SECTION

Name of Health Body

The established Health Body needs to be identified. If the redress case relates to the services of a hosted organisation, the relationship with the established health body must be outlined.

Reference ID

WRP Reference

Health Body Reference

LASPAR Reference

Legal & Risk Services Reference

Previously Redress? – please state YES or NO to identify whether or not the case has been transferred from management under the Redress process to the Claims process.

Covid19 Case? – please state YES or NO to identify if the case is related to the management of patients with coronavirus, contraction of infection or another matter related to the pandemic.

>£1m Case? – please state YES or NO to identify if the case is likely to exceed the delegated authority limit for expenditure by a health body

SECTION A: Case overview

A basic case summary of the circumstances of the events. This section is identical to the case summary section on the Learning from Events Report. Remember to Include the age and sex of the patient.

The name of the hospital or service and details of the unit or ward on which the incident occurred should be included.

An outline of the relevant events relating to the case is required, and this should where possible be presented in in chronological order.

Where appropriate, outline the long term outcome – whether the patient died or they continue to experience ongoing symptoms or have fully recovered.

SECTION B: Case investigation

How did the case become a claim (e.g. an Incident or Complaint with early admissions or a formal Letter of Claim on behalf of the Claimant)? State whether this case relates to a complaint or an incident. If via a complaint, when was the complaint received and who made it?

What evidence was gathered to support decision making in the case?

- Include a summary of all findings from the internal investigation.
- Include a summary of all findings from any expert reports.

Identify the advice re tactical options received from the conducting solicitor and why the case was settled and

SECTION C: Quantum& Costs

Outline the advice and guidance received in respect of quantum and costs in the case:

- How was quantum calculated in the case?
- What guidance or advice was obtained to determine the quantum?
- Were costs agreed within a fixed / capped framework?
- If the costs appear to be disproportionate compared to the damages value, please outline the reasons for this.

SECTION D: Decisions & Governance

- What decisions were made in the case by the health body?
- How did the organisation reach its decisions (meeting, SMT review, letter of advice from solicitor)?
- Specify which staff were responsible for decisions in the case? Give their job title e.g. Medical Director, Head of Patient Experience, Legal Services Manager etc.
- Was additional authority from Welsh Government required in order to settle this case (if so, when was this obtained)?
- How has the decisions and information about the case been shared with senior leaders within the organisation?

SECTION E: Case Management Declarations

The report must be signed by the claims manager responsible for the handling of the case, along with the appropriate authorised persons within the organisation.

Appendix D – Case Management Report – REDRESS

Checklist S22 v1.3

Case Management Report

NHS Redress - Case settled

Request to Welsh Risk Pool for reimbursement following payment of financial compensation under the Redress process

Name of Health Body		Hywel Dda University Health Board	
WRP Reference		Health Body Reference	
LASPAR Reference		L&R Reference	
WG SI Reference			

Has this case been transferred from Redress to Claims?	
--	--

Is this case related to arrangements, care or processes related to COVID19?	
---	--

CLINICAL NEGLIGENCE CASES	
Date QL determined in Redress Case	
Date of Financial Settlement	

- A Case Outline
- B Case Investigation
- C Quantum & Costs
- D Decisions & Governance
- E Supporting the Claimant
- F Declarations

A Case Outline

A01

B Case Investigation

B01

C Quantum & Costs

C1

C2 CRU – NIL

C03 NHS Charges NIL

D Decisions & Governance

D1

E Supporting the Claimant

E1 The claimant was supported during the Redress process by a solicitor, under the Fixed Fees Framework.

F Declarations

REDRESS CASE MANAGER'S DECLARATION

I have considered fully the management of this claim and my findings are recorded. I confirm that the details recorded in each relevant section are complete and accurate and that these aspects of the PTR guidance have been properly considered and actioned.

Signed by

Date

Print Name –

Position – **Redress & Legal Services Manager**

RESPONSIBLE BODY DECLARATION & AUTHORISATION

I confirm that the above details are complete and accurate and all aspects of the checklist have been properly considered and actioned. I agree that this payment offers the best value for money. I also confirm that:

- This case is within the delegated authority of this Responsible Body and is not novel, contentious or repercussive. I, therefore, agree to this special payment.
- The Responsible Body has complied with its obligations and the conditions set out in Welsh Government Guidance to enable it to exercise its delegated authority to settle claims valued below £1 million

Signed by -	Date
Print Name – Louise O'Connor	
Position – Assistant Director, Legal and Patient Experience	

Case Management Report

NHS Redress - Case settled

Request to Welsh Risk Pool for reimbursement following payment of financial compensation under the Redress process

Checklist and Guide to Completion

The Case Management Report (Redress Cases) is used by health bodies to outline how a case was investigated, managed in accordance with legislative requirements and what governance arrangements were used to reach decisions in the case.

The Report needs to provide sufficient information about the circumstances which led to the case and clearly outline the allegations of harm and Qualifying Liability determined, along with an explanation of the information, including internal and external expert advice that was gathered to inform a decision in the case.

REFERENCE ID & SUMMARY SECTION

Name of Health Body

The established Health Body needs to be identified. If the redress case relates to the services of a hosted organisation, the relationship with the established health body must be outlined.

Reference ID

WRP Reference

Health Body Reference

LASPAR Reference

Transferred Out? – *please state YES or NO to identify whether or not the case has been transferred from management under the Redress process to the Claims process.*

Covid19 Case? – *please state YES or NO to identify if the case is related to the management of patients with coronavirus, contraction of infection or another matter related to the pandemic.*

SECTION A: Case overview

A basic case summary of the circumstances of the events. This section is identical to the case summary section on the Learning from Events Report. Remember to Include the age and sex of the patient.

The name of the hospital or service and details of the unit or ward on which the incident occurred should be included.

An outline of the relevant events relating to the case is required, and this should where possible be presented in in chronological order.

Where appropriate, outline the long term outcome – whether the patient died or they continue to experience ongoing symptoms or have fully recovered.

SECTION B: Case investigation

How did the case come to the attention of the Health Body (Incident, Complaint etc)? State whether this case relates to a complaint or an incident. If via a complaint, when was the complaint received and who made it?

What evidence was gathered to support decision making in the case?

- Include a summary of all findings from the internal investigation.
- Include a summary of all findings from any expert reports.

Identify why qualifying liability was confirmed.

Specify if the case been transferred out of Redress into the Claims process and why this was done.

SECTION C: Quantum & Costs

How was quantum calculated in the case?

What guidance or advice was obtained to determine the quantum?

- If Judicial College guidelines were referred to, state the section that was used in order to quantify the damages.
- If damages were awarded for pain and suffering, how was the total calculated? Both the length and degree of pain and suffering should be referred to, in order to justify your calculation.

Specify whether Legal and Risk Services were consulted

Was the initial offer accepted? If not, what negotiations took place?

Outline whether costs were agreed within the fixed/capped framework and if not what steps were taken to manage costs? Specify whether there were issues in relation to costs in the case.

Were costs agreed within the fixed / capped framework?

Were there issues in relation to costs in the case?

SECTION D: Decisions & Governance

What level of staff were responsible for decisions taken in the case taken?

- Outline which staff were responsible for the internal investigation in this case? Give their job title.
- Specify which staff were responsible for decisions regarding the offer of redress? Give their job title e.g. Medical Director, Head of Patient Experience, Legal Services Manager etc.

How was the decision reached (eg panel, case review)?

If the offer of redress was made following decisions by a panel, outline what roles sit on the panel?

SECTION E: Supporting the Claimant

How was the Claimant supported throughout the investigation and decision-making process?

Who was the Claimant's point of contact? Give their job title.

Was there an independent advocate involved in supporting the claimant?

Was access to free independent legal advice utilised by the claimant? If so, identify the solicitors involved.

SECTION F: Case Management Declarations

The report must be signed by the redress case manager responsible for the handling of the case, along with the authorised person for decision making in the matter.

Appendix E – Examples of Documents for Disclosure

- Handwritten clinical notes
- Electronic notes
- E-mails
- Letters
- Lab Reports,
- X-rays reports
- Drug Charts
- Care Plans/assessments
- Printouts from monitoring equipment
- MDT minutes
- Best Interest Meeting Minutes
- Best interest Balance Sheets
- Deprivation of Liberty Papers
- Home Office Forms relating to detention under the Mental Health Act.
- Incident forms
- Photographs
- CCTV
- Audio/Video recordings
- Text messages
- Handover entries
- Ward diary entries
- Telephone notes
- Anything else upon which patient information is stored

‘Putting Things Right’ Management and Resolution of Concerns Policy (Incidents, Complaints and Claims)

Policy information

Policy number: 894

Classification:
Corporate

Supersedes:
514

Local Safety Standard for Invasive Procedures (LOCSSIP) reference:
N/A

National Safety Standards for Invasive Procedures (NatSSIPs) standards:
N/A

Version number:
3.0

Date of Equality Impact Assessment:
06/07/2023

Approval information

Approved by: QSEAC

Date of approval:
Enter approval date

Date made active:
Enter date made active (completion by policy team)

Review date:

Enter review date (normally three years from approval date)

Summary of document:

This Policy sets out the arrangements, under Putting Things Right, by which Hywel Dda University Health Board (the Health Board) will manage, respond and resolve concerns in order to meet the requirements of the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and subsequent amended regulations.

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).

Scope:

This policy applies to all staff who have a responsibility to report, manage and / or formally review concerns or be engage 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 recognises that independent contractors are under no obligation to adhere to this policy. However, the Health Board expects its independent contractors to have processes in place that meet the requirements of the Putting Things Right Regulations and the Duty of Candour requirements.

To be read in conjunction with:

[244 - Being Open / Duty of Candour Guidance and Duty of Candour Procedure](#) – opens in new tab

514 Incident Reporting Procedure

Management of Patient Safety Incidents and Serious Concerns Procedure

[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

Patient information:

[Putting Things Right: Raising a Concern about the NHS in Wales](#) – opens in new tab

[HDUHB Procedure for Raising a Concern](#) (website page) – opens in new tab

Owning group:

Nursing, Quality and Patient Experience Directorate

Listening and Learning Sub Committee

Date signed off by owning group

Executive Director job title:

Mandy Rayani – Director of Nursing, Quality and Patient Experience

Reviews and updates:

1.0 – New Policy

2.0 – Updated

3.0 – Updated

Keywords

Putting Things Right, Incident, Complaint, Claim, Concern, Duty of Candour, Being Open

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DRAFT

Introduction

Whilst modern health care is undoubtedly beneficial, it also has the potential of having harmful effects on patients. Estimates show that in high-income countries, as many as one in 10 patients is harmed while receiving hospital care. The harm can be caused by a range of adverse events, with nearly 50% of them considered preventable. (WHO, September 2019).

However, the provision of safe services is extremely important across all levels of health care, including in primary and out-patient care, where the bulk of services are offered. Globally, as many as four out of 10 patients are harmed while receiving health care in these settings, with up to 80% of harm considered to have been preventable. The most detrimental errors are related to diagnosis, prescription and the use of medicines (WHO, September 2019).

Therefore the organisation has a responsibility to ensure systematic measures are in place to safeguard people, property, NHS resources and its reputation. This also extends to ensuring that when a concern is raised (incident, complaint or claim) it is appropriately reviewed and an understanding of why the event occurred is established and ultimately, to ensure steps are taken to reduce the chance of either a similar concern happening again in a single organisation or, if appropriate, across the NHS as a whole.

This policy incorporates the arrangements required for the management of concerns in line with NHS (Concerns, Complaints and Redress) (Wales) Regulations 2011 (the regulations) and subsequent amendments and guidance documents. These regulations place a statutory responsibility upon NHS organisations in Wales to manage all concerns consistently and as set out in the Regulations. This includes where potential safeguarding concerns are identified, they are referred to child or adult protection procedures as appropriate in accordance with the duty to report an adult or child at risk in the Social Services and Wellbeing (Wales) Act 2014.

The Public Services Ombudsman (Wales) Act 2019 (the Act) created a new Complaints Standards Authority for Wales. In December 2020, all public sector providers received notification that in accordance with Section 36 of the Act, they were responsible for ensuring their complaint handling procedures were compliant with the following principles:

- a) Complainant Focused
- b) Simple
- c) Fair & Objective
- d) Timely & Effective
- e) Accountable
- f) Committed to Continuous Improvement.

This policy and all procedures related to the management of concerns will adhere to these principles and the Regulations referred to above.

Policy statement

It is the Health Boards aspiration that no patient should come to avoidable harm whilst under its care. Therefore, the Health Board shall ensure a systematic approach to the management, review and

resolution of concerns to reduce the likelihood of recurrence and to improve future patient outcomes and experience as well as services and the environment.

In doing so, the Health Board will promote a learning culture which focusses on identifying causal factors rather than blaming individuals, by sharing and implementing the lessons learned.

This policy, and associated written control documents, do not take precedence where there is a child or adult identified as being at risk, or who is experiencing or is at risk of abuse or neglect. In such instances these cases must be reported to the relevant Local Authority Safeguarding Team or Police in line with the Social Services and Well-Being (Wales) Act 2014, All Wales Child Protection Procedures and the Health Board Safeguarding Adults at Risk Policy. The reporting and escalation of safeguarding concerns should run in parallel to this policy, however incidents must not be investigated via this process unless authorised by Police or the Local Authority Safeguarding Team. Advice in relation to safeguarding incidents can be sought from the Health Board Corporate Safeguarding team.

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 recognises that independent contractors are under no obligation to adhere to this policy. However, the Health Board expects its independent contractors to have processes in place that meet the requirements of the Concerns, Complaints and Redress regulations.

Aim

The aim of this policy is to ensure that there is a systematic person centred approach to the management, review and resolution of concerns which reduces the likelihood of recurrence and to improve future outcomes and patient experience as well as services and the environment

Objectives

The aim of this document will be achieved by the following objectives:

- Developing an organisational culture, which allows concerns to be reported in an open and fair environment and complies with the legal duty of candour
- Analysing and learning from when things go wrong
- Development of a learning culture throughout the organisation; and
- Resolving system failures and improving service delivery.

Principles

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 Llais (formerly Community Health Councils in Wales).

The general principles are:

- Concerns are dealt with efficiently, openly, sympathetically, in a timely manner and with a person centred approach;
- The person raising the concern will be treated with respect and courtesy, with confidentiality maintained if requested;
- The formal review (investigation) will be proportionate to the severity of the concern raised (see [appendix 1](#) for levels of harm which is equally applicable to complaints and incidents);
- The person raising the concern will be guided to independent support or advocacy, if required, for example Community Health Council and Public Services Ombudsman for Wales.
- A named Health Board contact will be allocated, usually the Reviewing Officer, who will make early and regular personal contact with the person raising the concern;
- Action will be taken to address any areas for improvement and learning;
- The concern will be managed in line with Welsh Government regulations and the Statement of Principles
- Consideration will be given to of an offer of Redress, in accordance with the Regulations, where investigation or formal review into the matters raised reveal that there is a qualifying liability in tort.

Definitions

Concern

A “concern means any complaint; notification of an incident or, save in respect of concerns notified in respect of primary care providers or independent providers, a claim for compensation” (Welsh Government 2011).

Complaint

A “complaint means any expression of dissatisfaction”. (Welsh Government 2011)

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.

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 in the course of 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).

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.

Redress

Under the [The NHS Concerns, Complaints and Redress Arrangements Wales Regulations 2011](#) (opens in new tab), the Health Board is required to consider when investigating a concern whether there is a qualifying liability in tort i.e. whether there has been a breach of our duty of care and whether that breach of duty is causative of any harm or loss to that person. Where this is indicated there is a qualifying liability in tort and a consideration of an offer of redress is necessary.

Redress can take the form:

- An Apology
- Remedial Action
- Investigation or formal review and explanation
- Financial compensation up to £25,000

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

Primary considerations of practice

Who can raise a concern

Almost anyone can raise a concern. However, it might not always be possible to share the full details of the formal review with the person raising the concern, for instance, if they are not the patient or person that the patient has consented as acting on their behalf.

Concerns can be raised by:

- People who are receiving or who have received services from the Health Board;
- People affected or likely to be affected by the actions, errors or decisions of the Health Board;
- Staff members of the Health Board;
- Independent members (non-executive director or non-officer) of a NHS body;

- Partners, e.g. a partner in a GP practice;
- A third party acting on behalf of a person who is unable to raise a concern e.g. a young child or someone who lacks capacity to act on their own behalf; or because that person wants someone else to represent them;
- A third party on behalf of a person who has died.

Single Point of Entry

People can raise concerns in a variety of ways:

Phone: 0300 0200 159

Email: hdhb.patientsupportservices@wales.nhs.uk

Letter: FREEPOST FEEDBACK@HYWEL DDA

Text: 07891 142240

The Health Board considers each of the above to be a single point of entry e.g. if a concern is raised by phone, the person will not be expected to formally write to the Health Board.

Staff can also raise concerns through the Health Board's Incident Reporting Procedure or through the All Wales Procedure for NHS Staff to Raise Concerns which should be considered before using the details provided above.

Acknowledgement

All concerns (incidents, complaints and claims) will be logged on a central system and an acknowledgement of receipt sent to the person raising the concern (where contact details have been provided). In line with the Putting Things Right Regulations, the acknowledgement must be sent within five working days of first receipt. Any person raising a concerns will be treated with compassion and understanding.

Being Open / Duty of Candour

When a concern has occurred, it is essential that all staff comply with Hywel Dda UHB Being Open/Duty of Candour Procedure (see [appendix 3](#)) and ensure that the person is offered an apology and given an explanation as soon as possible after the duty of candour has been triggered (within 30 days). This should be in person (face to face or telephone). It is important to note that saying sorry is not an admission of liability. Following this, a follow up letter, in line with the agreed template, should be provided within 5 working days.

The guidance at [Appendix 3](#), provides a process for reviewing an incident to determine whether the Duty of Candour is triggered; the procedure to follow when enacting the duty of candour; and guidance on making a meaningful apology.

Multidisciplinary Responsibility

Most healthcare provision is through multidisciplinary teams. This should be reflected in the way that patients, their families and carers are communicated with when things go wrong. This will ensure that the Putting Things Right process is consistent with the philosophy that concerns usually result from system failures and rarely from the actions of an individual.

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.

Proportionate and Appropriate Formal Review

Identifying the cause and contributory factors of the concern will focus the formal review and help to improve the systems of care. The principle of conducting a thorough and proportionate formal review into a concern and reassuring the person that lessons have been learned will help to prevent the event recurring. The Yorkshire Contributory Factors Framework (YCFF) has been built into Datix Cymru to support a consistent approach to the analysis of incidents.

Information about the formal review must be given to the staff involved in a truthful and open manner although if imparting this information may jeopardise the formal review, then it is advised not to inform the member of staff.

Information given to patients and staff is based solely on the facts known at the time. Healthcare professionals should explain that new information may emerge as the investigation or formal review is undertaken and that patients, their families and carers will be kept up to date with the progress of the investigation or formal review.

All concerns reported in NHS Wales, including patient safety incidents, must be subject to an appropriate and proportionate investigation in line with the NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. In particular, Regulation 23 outlines the requirements of the investigation to be undertaken and requires the organisation to undertake the investigation in the manner that appears, to that organisation, to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently.

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.

Governance Framework

All concerns with significant learning will be reported to the Listening and Learning Sub-Committee and/or the Operational Quality, Safety and Experience Sub-Committee. The concerns raised will form part of the regular assurance reports to the Quality, Safety, and Experience Committee. Details of the subject and nature of the concern together with the outcome of the investigation must be recorded.

Compliance with the stated time periods for response are monitored and reported. The Board is made aware of concerns which may adversely affect the reputation of Board by the Chair of the Quality, Safety and Experience Committee.

The time periods set in the Putting Things Right Regulations are:

Complaints (concerns considered under Regulation 24)

- Final responses should be issued within 30 working days of first receipt of the concern, but if this is not possible the person raising the concern must be informed of the reason for delay.
- When a response cannot be issued within 30 days, the response must then be sent as soon as possible and within 6 months of the date the concern was received.
- If, in very exceptional circumstances, the response cannot be issued within 6 months, then the person raising the concern must be informed of the reason for delay and given an expected date for response.
- This policy will ensure the Health Board complies with the requirements of the Putting Things Right – Management of Concerns Guidance 2023.
[Putting Things Right Leaflet \(gov.wales\)](#) (opens in new tab)

Patient Safety Incidents

- The principle of timely and proportionate investigation is paramount.
- For the majority of incidents, the investigation should be completed within 60 days.
- This policy will ensure that the Health Board complies with the requirements of the National Policy on Patient Safety Incident Reporting (2023)
du.nhs.wales/files/incidents/national-policy-on-patient-safety-incident-reporting-2-0-pdf/ (opens in new tab)

Roles and Responsibilities

Chief Executive

The Chief Executive Officer has overall responsibility for dealing with concerns. This responsibility has been delegated to the Director of Nursing, Quality and Experience with day-to-day responsibility delegated to the Assistant Director (Legal Services & Patient Experience).

Non-Officer (Independent Member of the Board)

The delegated non officer for the Health Board is responsible for maintaining a strategic overview of the Policy (Regulation 2.6). This person is responsible, in particular for:

- 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 in order 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. (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.

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

The Director of Nursing, Quality and Patient Experience is the Responsible Officer for overseeing the day to day management of these arrangements and ensuring that the Health Board operates in an integrated manner to:

- Deal with concerns in line with the Regulations;
- Allow for the consideration of qualifying liability; and
- Provide for concerns to be dealt with under a single governance arrangement.

The responsibilities of the Director of Nursing, Quality and Experience are delegated to the Assistant Director (Legal Services/Patient Experience), but remain under the direct control and supervision of the executive lead.

Other Directors

All Executive Directors and Directors are responsible for supporting the Chief Executive in their responsibility and supporting the directorate managers, clinical directors and medical staff in implementing this policy across the organisation.

Senior Investigations Manager

The handling and consideration of concerns in accordance with the Regulations will be the responsibility of the Senior Investigations Manager. As well as the handling and consideration of concerns under the Regulations, part of the Senior Investigations Manager's role will require them to undertake other functions in relation to dealing with concerns and to co-operate with other persons or responsible bodies, e.g. primary care providers, to facilitate the handling and investigation or formal

review of concerns. The Senior Investigations Managers provide leadership and advice to the Board, clinicians and managers on patient safety and on the handling and management of concerns. This includes implementing a system across the Health Board which ensures remedial actions are taken to avoid recurrence of concerns and the sharing of lessons learnt across the organisation and beyond. This role is supported by additional suitably trained staff as part of the integrated arrangements.

The Senior Investigations Manager is the Assistant Director (Legal Services/Patient Experience)

Directorate Managers / Triumvirate Teams

The directorate managers/triumvirate teams have responsibility to make sure that the principles outlined within this policy are implemented within their directorate/hospital including fostering a culture for learning from experience and sharing lessons learned.

They are responsible for disseminating lessons learned to colleagues within their directorate and other directorates in the Health Board, providing opportunities for learning through team meetings, shared learning events and with colleagues in other directorates where appropriate.

It is the responsibility of the Heads of Nursing to escalate any fitness to practice concerns to the Director of Nursing, Quality and Patient Experience.

It is the responsibility of the Hospital Clinical Director to escalate any fitness to practice concerns to the Executive Medical Director or Executive Director of Therapies and Health Science.

Ensure lessons learnt are recorded on Datix and there are plans in place to monitor implementation and assess effectiveness.

Heads of Service / Departmental Managers

Heads of service/departmental managers have a responsibility to foster a culture of learning from concerns.

Ensuring staff have the knowledge and skills to manage concerns.

They are responsible for disseminating lessons learned to colleagues within their directorate/hospital, providing opportunities for learning through team meetings and with colleagues in other divisions where appropriate.

Responsibility of All Staff

All staff are responsible for ensuring that they:

- Work to the principles outlined in this policy, and associated written control documents;
- Learn from concerns; and
- Co-operate fully and openly in the investigation or formal review of a concern
- Ensure lessons learnt and action plans are uploaded to the Datix file and monitored appropriately through the relevant governance arrangements (the responsibility for this rests with the service leads not concerns team).

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.

In order 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 when information highlights potential issues of alleged personal/professional misconduct. To support this process the Health Board will follow the principles laid out in "[a just culture guide](#)" (opens in new tab) published by NHS Improvement.

References

The Health and Social Care (Quality& Engagement) Act (Wales) 2020

<https://www.legislation.gov.uk/asc/2020/1/contents/enacted>

The National Health Service (Concerns, Complaints & Redress) Regulations (Wales) 2011

<https://www.legislation.gov.uk/wsi/2011/704/contents/made>

As amended (2023) <https://www.legislation.gov.uk/wsi/2023/281/made>

Putting Things Right – Management of Concerns Guidance (2023)

[Putting Things Right Leaflet \(gov.wales\)](#)

The Duty of Candour Procedure (Wales) Regulations 2023

<https://www.legislation.gov.uk/wsi/2023/281/made>

The Duty of Candour Statutory Guidance 2023

<https://www.gov.wales/duty-candour-statutory-guidance-2023>

The Duty of Quality Statutory Guidance 2023

[Duty of Quality Statutory Guidance \(gov.wales\)](#)

National Policy on Patient Safety Incident Reporting (2023)

du.nhs.wales/files/incidents/national-policy-on-patient-safety-incident-reporting-2-0-pdf/

NHS Improvement (undated) [A Just Culture Guide](#)

Health Board Supporting written control documents

- Being Open/Duty of Candour Guidance (244)
- Incident Reporting Procedure
- Management of Patient Safety Incidents and Serious Concerns Procedure
- Policy for Claims Management (004)
- Staff Attending Inquests/Court and Assisting with Police Investigations
- Guideline (018)
- Management of Nursing and Midwifery Medication Errors/Near Miss Policy (558)

Other 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 1 – 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	<p>Any patient safety incident that had the potential to cause harm but impact resulted in no harm having arisen.</p> <p>e.g: Appointment delayed, but no consequences in terms of health.</p> <p>e.g: Patient fall – where no harm was suffered or additional interventions required.</p> <p>e.g: Near miss – where the potential for harm was noticed and action taken to avoid occurrence of harm.</p>
Low harm/minimal harm	<p>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.</p> <p>Minor increase in treatment could include:</p> <p>e.g: First aid, additional therapy, medication or rehabilitation</p> <p>e.g: Patient fall - requiring one off observations and/or minor treatment.</p> <p>e.g: Increase in length of stay by 1 - 3 days.</p>

	<p>When does the duty of candour apply?</p> <p>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</p> <p>The duty is triggered in relation to an NHS body if it appears to the body that both of the following conditions are met:</p> <ul style="list-style-type: none"> (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. <p>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</p>
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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.

	<p>could experience, any unexpected or unintended harm that is moderate or above.</p> <p>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.</p> <p>The duty is not triggered where harm is related to the natural course of the service user’s illness or underlying condition.</p>
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Unexpected or unintended moderate harm	<p>Examples of unexpected or unintended levels of moderate harm and types of incidents that <u>would</u> trigger the duty of candour procedure include:</p> <p>Moderate harm –</p> <ul style="list-style-type: none"> (a) moderate increase in treatment and (b) Significant but not permanent harm. <p>Moderate increase in treatment could include:</p> <ul style="list-style-type: none"> • 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. <p>Examples of the type of incidents that would trigger the duty of candour procedure include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Description of incident - A mother had significant post-partum haemorrhage after a difficult delivery, and there was a delay in obtaining blood for transfusion.</p>
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	<p>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.</p>
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	<p>The service user experiencing psychological harm:</p> <p>Psychological harm – means a psychiatric condition or the exacerbation of an existing psychiatric condition for a continuous period of at least 28 days.</p> <p>NB: The timeframe above should be used as a measure only. The focus must be on the level of unintended or unexpected harm.</p> <p><u>Further detailed case study examples can be found in Annex H.</u></p>
Unexpected or unintended severe harm	<p>Examples of unexpected or unintended levels of severe harm and types of incidents that <u>would</u> trigger the duty of candour procedure include:</p> <p>Severe harm would include:</p> <ul style="list-style-type: none"> • 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 <p>Examples of the type of incidents that would trigger the duty of candour procedure include:</p> <p>Description of incident - loss of recovery potential. Delays in thrombolysis or AHP treatment.</p> <p>Level of harm as a result - resulting in loss of recovery of walking or speech, which is permanent.</p> <p>Description of incident - Patient suffers an adverse reaction to medication that they are documented to be allergic to.</p> <p>Level of harm as a result – Leading to the patient suffering brain damage or other permanent organ damage.</p> <p>Description of incident - Patient suffer a perforation of the bowel during surgery.</p>

	Level of harm as a result – Leading to patient requiring a colostomy and/or subsequent operations.
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	<p>Description of incident - Patient did not receive a planned follow up x-ray.</p> <p>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.</p> <p><u>Further detailed case study examples can be found in Annex H.</u></p>
Unexpected or unintended death	<p>Examples of unexpected or unintended death and types of incidents that <u>would</u> trigger the duty of candour procedure include:</p> <p>Examples of the type of incidents that would trigger the duty of candour procedure include:</p> <p>Description of incident - Wrong blood transfused.</p> <p>Level of harm as a result - Leading to multi-organ failure and a fatal cardiac arrest.</p> <p>Description of incident - Patient suffers an adverse reaction to medication that they are documented to be allergic to.</p> <p>Level of harm as a result - Leading to severe anaphylaxis and subsequent death.</p> <p>Description of incident - Patient presents with chest pains and is asked to wait in clinic/practice/emergency department.</p> <p>Level of harm as a result - Patient suffers a fatal myocardial infarction in the waiting area, which they then die from.</p> <p><u>Further detailed case study examples can be found in Annex H.</u></p>

Appendix 2 – Supporting Staff – Assist me model

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

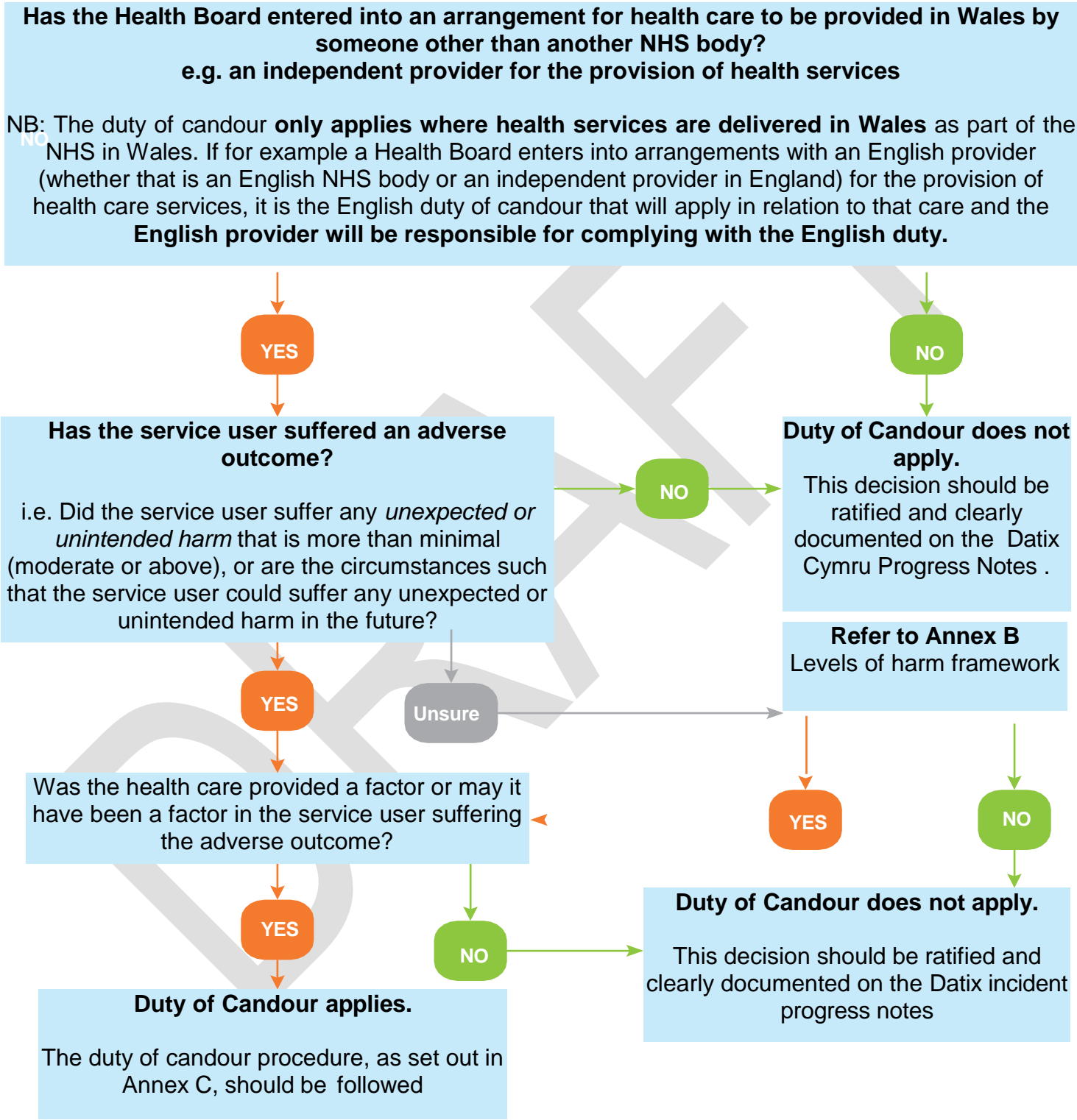
Employee Assistance Programme (EAP) is a free, confidential counselling service and offers support for you or your team when required and following a critical incident.

EMPLOYEE ASSISTANCE PROGRAMME (EAP)
CALL 0818 327 327

Go to www.hse.ie/EAPandME to access the online hub of helpful resources.



Appendix 3 – 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
<ul style="list-style-type: none">• 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'

Appendix 4 – Public Services Ombudsman for Wales – Complaint Handling Processes statement of Principles

Effective complaints handling processes should be:

- 1) Complainant Focused
- 2) Simple
- 3) Fair & Objective
- 4) Timely & Effective
- 5) Accountable
- 6) Committed to Continuous Improvement

1) Complainant Focused

The complainant should always be at the centre of the complaints process.

Service providers need to be flexible when responding to complainants' differing needs.

2) Simple

Complaints processes should be well-publicised, have easy-to-follow instructions and have no more than two stages.

Information on advocacy services and support should be available.

Complaints responses should set out clearly the next stage and the right to approach the Ombudsman.

3) Fair & Objective

Complainants should receive a complete and appropriate response to their concerns.

Complainants and staff complained about should be treated equally and with dignity.

4) Timely & Effective

Complaints should be resolved promptly, when possible

Investigations should be thorough, yet prompt.

Complainants should be kept informed throughout of the progress of a lengthy investigation.

5) Accountable

Complainants should receive an honest and clear explanation of the findings of an investigation.

Service providers should explain to complainants what changes will be made if their complaint is upheld, whenever possible.

6) Committed to Continuous Improvement

Information from complaints should be collated and analysed.

Data should be shared with the organisation's senior leaders and the Ombudsman to support improvement in complaint handling and in service delivery.

Decision makers should regularly review the information gathered from complaints when planning service delivery.

DRAFT