AGENDA ITEM 3.3

9 August 2011

PUTTING THINGS RIGHT/NHS REDRESS
PROGRESS WITH IMPLEMENTATION

Report of
Nurse Director

Paper prepared by
Assistant Director of Patient Safety & Quality

Executive Summary
On 1st April 2011, the Welsh Government (WG) introduced new Regulations in relation to ‘Putting Things Right / NHS Redress’ which Regulate changes to the way NHS Wales manages ‘concerns’ (complaints, patient safety incidents and small value claims), to ensure that mistakes are identified and put right, an open apology is provided and that lessons are learned to avoid a recurrence.

Standard 23, (Standards for Health in Wales 2010) Dealing with concerns and managing incidents, outlines the arrangements NHS Wales establish to respond to ‘concerns’ in the following way;

Organisations and services comply with legislation and guidance to deal with complaints, incidents, near misses, and claims - known collectively as ‘concerns’ which ensure that they:

a) are reported, acted upon and responded to in an appropriate and timely manner;

b) are handled and investigated openly, effectively and by those appropriately skilled to do so;
c) offer patients, service users and their carers support including advocacy and where appropriate redress;  
d) provide appropriate support to staff; and  
e) learn and share lessons from local and national reviews to improve services.

The Nurse Director and Assistant Director of Patient Safety & Quality gave a presentation at the last meeting of the Quality and Safety Committee, outlining the key changes to the Regulations and the related impact these changes are having on the UHB.

The UHB has made good progress in implementing the infrastructure to respond to this increasing agenda. However, the report also outlines key challenges, including the impact of the quarter 1 increased related ‘concerns’ activity and the pragmatic risk based approach to prioritising ‘concerns’ using incident grading criteria.

In addition the Concerns Panel has asked for a resource impact plan on the additional activity this agenda, applying the new Regulations has created for the UHB.

| Action/Decision required | The Committee is asked to:  
| --- | ---  
| NOTE the work undertaken in response to the new Regulations |  
| |  
| Link to other Board Committee (s) and sub-committees | This agenda item is also being considered and scrutinised by the Concerns Panel.  
| |  
| Link to Standards for Health Services in Wales | This report provides assurance on compliance with Health Standard 23 – Dealing with Concerns and managing incidents.  
| |  
| Link to Public Health Agenda | An improvement in the arrangements for dealing with concerns and managing incidents with an emphasis on learning will improve the health and well being of the population  
| |
| **Link to UHB Strategic Direction and Corporate Objectives / Legislative and Regulatory Framework** | To help ensure the UHB delivers its vision, achieves its objectives, meets Welsh Assembly Government targets and complies with the legislative and regulatory framework. In particular, that the highest standards of quality and safety are maintained |
| **Link to relevant evidence base** | Information is drawn from a number of sources including: |
|  | • Putting Things Right/NHS Redress (April 2011) |
|  | • Quality & Safety Dashboard |
INTRODUCTION

On 1st April 2011, the Welsh Government (WG) introduced new Regulations in relation to ‘Putting Things Right / NHS Redress’. These new Regulations require NHS Wales to change the way in which concerns (complaints, patient safety incidents and small value claims) are managed, to ensure that mistakes are identified and put right, an open apology is provided and that lessons are learned to avoid a recurrence.

The Welsh Government (WG) wants to improve the way that health organisations deal with concerns about the health service. They want the health service in Wales to do as much as it can to put right mistakes and to learn lessons to stop them happening again.

WG feel that this can be done by improving the arrangements already in place to support all staff to be open with people when something has gone wrong and by developing further the skills and experience of staff who will investigate concerns.

Standard 23, (Standards for Health in Wales 2010) Dealing with concerns and managing incidents, outlines the arrangements NHS Wales will be required to have in place to respond to ‘concerns’ in the following way;

Organisations and services comply with legislation and guidance to deal with complaints, incidents, near misses, and claims - known collectively as ‘concerns’ which ensure that they:

a) are reported, acted upon and responded to in an appropriate and timely manner;

b) are handled and investigated openly, effectively and by those appropriately skilled to do so;

c) offer patients, service users and their carers support including advocacy and where appropriate redress;

d) provide appropriate support to staff; and

e) learn and share lessons from local and national reviews to improve services.

WG also believe that by giving health organisations the tools and techniques they need to carry out better investigations, more people will be satisfied with the result.
The new arrangements should be easy to access and people should be able to get help and support to raise their concerns.

There is already a lot of good work going on and there are many people with skills and experience in the NHS in Wales and elsewhere who are working hard to put things right when they do go wrong.

The Nurse Director and Assistant Director of Patient Safety & Quality gave a presentation at the last meeting of the Quality and Safety Committee, outlining the key changes to the Regulations and the related impact these changes are having on the UHB.

The new system is effective from April 2011. Attached as an Appendix, are flow charts issued by Welsh Government to explain application of the new Regulations.

This report focuses on the actions taken by the UHB to respond to these new Regulations and identifies areas of the Regulations that require further more focused work.

**SUMMARY OF KEY CHANGES**

From April 2011, all ‘concerns’ not resolved on the day that they are raised, significantly, these include concerns raised by staff when reporting patient safety incidents, will need to be considered under the new Regulations.

In effect, this means that in comparison to the activity previously dealt with under the All Wales Complaints Procedures, the following activity routinely reported within the UHB, now falls into the new Regulations;

<table>
<thead>
<tr>
<th>Activity Area</th>
<th>Pre 2011 (All Wales Complaints Process)</th>
<th>Post 2011 New Regulations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal Complaints</td>
<td>750</td>
<td>750</td>
</tr>
<tr>
<td>Informal Complaints</td>
<td>3000</td>
<td>3000</td>
</tr>
<tr>
<td>Clinical Negligence Claims</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td>Independent Reviews *</td>
<td>50</td>
<td>N/A</td>
</tr>
<tr>
<td>Public Services Ombudsman Wales **</td>
<td>50</td>
<td>?</td>
</tr>
<tr>
<td>Patient Safety Incidents</td>
<td>N/A</td>
<td>15,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>Approx 4,000</strong></td>
<td><strong>Approx 19,000</strong></td>
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</tbody>
</table>

* Removed from the new process
** Difficult to predict number of requests for independent review
During quarter 1 (April – June 2011), in comparison with formal and informal complaints activity in the same quarter last year, the UHB experienced a 20% increase in formal concerns and an 85% increase in reported informal concerns.

**WHAT IS CHANGING?**

The main changes are:
- A requirement to be more open with people;
- One investigation, in proportion to what has happened;
- More support for patients and staff;
- Taking more account of people’s needs;
- More time to investigate when needed;
- Duty on NHS organisation to look at whether they are legally at fault;
- Simpler one-stage process;
- Better information about what lessons have been learnt and what improvements have been made to services.

In addition to the above, during 2010, the Public Services Ombudsman Wales (PSOW) concluded a consultation on the development of one Public Body Complaints Handling Process in Wales, which takes into account these new regulations.

**Why Regulate?**

Patients and their families, and those who help them to take forward their concerns (carers/advocates) have told WG that people do not always find it easy to say they are unhappy about their care and that when they do, they are not satisfied with the way in which their concern is dealt with.

Many people would prefer to raise concerns as soon as something happens and have the matter sorted out on the spot but do not always feel they can do this because they fear that members of staff are too busy. Other evidence suggests that people are concerned that their healthcare will be affected if they complain, or that they will be struck off their doctor’s list. Many people feel there is not enough openness in the way concerns are dealt with.

Organisations felt that the separate processes for handling complaints, claims and incidents did not allow them to carry out investigations that are in proportion to what has happened.
They also felt that the processes did not link together enough. This meant that the same issue could be investigated more than once, and that opportunities for learning lessons missed.

There is consensus that there is a need to focus on obtaining a fair outcome for patients and staff in these circumstances and the new arrangements will result in a better way of handling concerns which:

- Is easy for people to use;
- People can trust to deliver a fair outcome;
- Recognises their individual needs (language, support, etc);
- Is fair in the way it treats patients and staff;
- Makes the best use of time and scarce resources;
- Pitches investigations at the right level of detail for the issue being looked at, and
- Can show that lessons have been learned.

Prior to the new Regulations coming into effect, NHS organisations were guided to bring together staff that currently manage ‘concerns’ within a single team accountable to a Board Member. In Cardiff and Vale UHB, as part of its restructuring in 2010, all functions responsible for ‘concerns’ were brought together under the Assistant Director of Patient Safety and Quality and reporting to the Executive Nurse Director.

How the Welsh Government believes the arrangements should look

One of the biggest problems facing people wanting to raise a concern is that they often do not know how. Some people make a complaint; others may consider taking legal action. Similarly, if members of staff think that something has gone wrong, they may be unsure how to behave and who to tell. WG want to make this easier by having one system at the outset.

People who want to raise concerns may often be upset and worried about their own care or that of a family member, or in the case of staff, fear that they may have harmed a patient and the impact that this may have not only on the patient, but on themselves as well. WG want to ensure that the process of raising a concern does not add to the stress they may already be feeling by keeping them informed, being open and giving them the support they need.
WG have replaced the current two-stage complaints process of local resolution and independent review with a simpler, one-stage process for looking into all concerns, run by highly trained teams of people based in the NHS organisations. This will include looking at a situation to see if the NHS organisation is legally at fault and whether compensation should be offered.

The number of such cases is likely to be small, but it is important that they are included, so that the NHS learns lessons from them. It is also important to give the message that people should not have to fight legal cases if an issue can be resolved locally.

Every effort will be made to put matters right, but people will still be able to take their case to the Ombudsman, or to the Courts (if they believe there is legal fault) if they are not happy. The new Regulations will therefore provide the following:

Patients and families

- Any patient, including a child, can raise a concern;
- A family member or other person can raise a concern on behalf of a patient, with the person’s consent;
- Will have up to three years to raise a concern, although normally people will be expected to raise their concern within a year, because otherwise it becomes more difficult to investigate;
- People can raise their concerns in any form – verbally (in person or by telephone) or in writing (letter or e-mail);
- Concerns can be about any service provided by or any decision made by a health service organisation or family health service provider in Wales;
- If a concern is raised and it can be dealt with on the spot, then it will be;
- Those raising the concern to be contacted within 2 days with further information on how their concern will be dealt with and how long it may take;
- Those raising the concern, to be asked whether they have any particular needs to enable them to take forward their concern (e.g. language; easy read; Braille; hearing assistance; cultural issues);
- If required those raising the concern will be provided with advocacy support from a Community Health Council or specialist service);
- There will be a different process for decisions about individual patient funding because these cases often need to be reviewed more quickly;
FOR INFORMATION

- Advised of a named individual who will be their point of contact throughout the investigation of their concern;
- Receive a response within 30 days or sooner in the majority of cases;
- For every effort to be made to resolve their concern, including independent advice, second opinions or remedial treatment;
- To be kept informed on a regular basis if the investigation is going to take longer and the reasons why;
- For most complex cases to be resolved within 6 months;
- To be offered legal advice free of charge, if the NHS organisation agrees they are liable to pay compensation, to check that the offer is fair;
- If an offer of compensation is accepted, to agree not to take legal action about the same issue;
- Are able to take their concerns to the Public Services Ombudsman for Wales (or the Courts if they believe there is legal fault) if they are not happy with the NHS organisation’s attempts to resolve their concerns.

What NHS staff can expect

- If concerns are raised by a patient or family member and resolved on the spot, frontline staff will report the issue to the central team so that lessons can be shared;
- To be supported to be open with patients when something has gone wrong, including being put in touch with a trained Being open mentor;
- To be treated fairly during an investigation and to be given regular updates;
- Will be provided with the appropriate level of support to help them deal with the situation;
- Will be able to comment on investigation reports;
- Will be able to involve their trade union or defence organisation if they want to;
- Can be assured that actions will only be taken that are in proportion to the issue being looked at.

Impact on NHS organisations and family health services providers

- There will no longer be separate processes or departments for managing complaints, claims and incidents - a single, integrated, multi-skilled team will manage all concerns;
- This central team will work with staff across the organisation to ensure that investigations are carried out to a consistent standard;
• Specific staff will be trained to deal with various types of concern, including recognising and quantifying situations where the organisation may have been legally at fault;
• The central team’s senior manager will report directly to an Executive Director on the Board, to be either the Medical or Nurse Director;
• Complaints about family doctors, dentists, community pharmacists (chemists) and opticians should be investigated first by the practice, but the local health board team can become involved if necessary – this can be requested by the patient or the practice;
• It will be the responsibility of the NHS organisations to make sure that there are sufficient staff employed to look into concerns and that they are trained and keep their skills up to date.

The new process
• Normally, concerns should be raised within a year of the incident or of the date that the incident became known, but can be raised up to three years later in some cases;
• If it is possible to investigate, even if a long time has passed, then the organisation should consider it, if it is reasonable to do so;
• Concerns will be graded when they are received so that the right level of investigation can be carried out;
• Investigations should not be held up in waiting for consent from patients – organisations should consider whether there are any patient safety or public interest reasons for proceeding. This should be explained to patients and staff at the beginning of the process when consent is being asked for;
• Various tools should be considered, as appropriate, to help to resolve a concern – these could include independent clinical advice; independent facilitation or specialist advocacy and these should be considered and planned for as early as possible in the process rather than offered “after the event” or as a last resort;
• If the organisation believes it may have been legally at fault and proceeds to investigate this further, then the date of the decision must be noted formally. This will then suspend the “Limitation Period” whilst the investigation carries on (this is the time available to a person to take legal action in the courts, usually 3 years; longer in the case of children);
• Compensation payable under the arrangements has been consulted upon based on a proposal of £25,000 for pain, suffering and loss of amenity (general damages) and actual financial losses (special damages) will be calculated on top of this.
This would allow NHS organisations wishing to settle matters if they feel able to do so. On the other hand, it recognises the limitations of the arrangements in dealing with matters of significant complexity or high value in which the current litigation system may better serve the patient;

- To assist organisations to quantify claims, a tariff system will be developed to provide a reference system which will ensure consistent quantification of matters across Wales. This will be updated on a frequent basis;
- If compensation is payable in relation to a child, then an Infant Settlement Approval hearing may be required to protect the interests of the child;
- Legal advice to be provided by specialist solicitors;
- NHS organisations will have to report activity to the Welsh Government on revised statistical returns and to their citizens in their annual reports.

**Interim Guidance to inform the changes proposed within the new Regulations**

Interim guidance issued by WG in September 2009, required a number of actions by Health Boards to ensure their organisation and its related arrangements were structured to respond to the new regulations. This included the following:

<table>
<thead>
<tr>
<th>Action Required</th>
<th>Status</th>
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<tbody>
<tr>
<td>1. Identify a relevant Executive Director (we anticipate this to be the Medical or Nurse Director) to have specific responsibility for this aspect of the quality agenda (see also 10 below). This director should work with an identified non officer/ non-executive lead to ensure that the importance placed on this process is reflected at Board level in every organisation. This needs to be articulated within the organisations’ governance and accountability framework and assurance processes.</td>
<td>Executive Nurse Director is Executive lead; The Chairman of the UHB Chair’s the UHB Concerns Panel. The Vice Chair of the UHB Chairs the Quality and Safety Committee where the ‘concerns’ agenda also sits.</td>
</tr>
<tr>
<td>2. Develop an integrated structure which brings together complaints, claims and incident investigation processes under a single governance umbrella. Identify a senior manager with the requisite skills to develop and lead the department, reporting directly to the Executive Lead.</td>
<td>Revised UHB management structure implemented in line with interim guidance. This includes an Assistant Director post overseeing the department and reporting to the lead Executive</td>
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3. Undertake a skills/training needs analysis in the Autumn. | Training needs analysis undertaken and submitted to WG.

### More robust investigations and learning

4. Ensure that a robust incident investigation structure is implemented consistently throughout the organisation to ensure that investigations are owned locally but that the process is overseen by the Senior Investigations Manager. This should include mechanisms for learning and aligning with quality and safety improvement priorities. | Additional staff trained to inform Root Cause Analysis based training. Improved alignment of the learning resulting from incident investigation within the revised Corporate and Divisional structures.

5. Provide individuals with the name of the person they can contact throughout the investigation of their concern at the start of the process with the emphasis being on effective local resolution, proportionate to the issue being raised. | Established, although the volume of activity in quarter 1 is a limiting factor.

6. Ensure that the communication and other support needs of patients are fully addressed at the outset of any concern being raised, to enable people to engage effectively and positively with the process. | Established, although the volume of activity in quarter 1 is a limiting factor.

7. Conduct a thorough investigation rather than being overly concerned about timescales, but agree realistic timescales beforehand if possible, and keep the person who has raised the concern regularly informed and involved. | Timescales for investigation remain a challenge, not least due to the increased volume of activity in quarter 1. However, keeping patients updated on progress with investigations and reasons for delays is being targeted as we implement the new arrangements.

8. Note that if the patient is making a complaint themselves, that there is no need to expressly seek their consent to the use of their medical records, but to inform them in the acknowledgement letter that their records may need to be examined. | Implemented.
9. Consider best practice in investigation techniques (using root cause analysis principles) to deliver a full and meaningful investigation, proportionate to the range of issues involved and start to consider the staffing and skill mix needed to achieve this within your organisation and the structure to support this.

   Additional UHB staff trained to support requirement for additional RCA based investigation.
   
   From February - July 2011, an additional 70 staff have been trained.

10. Boards may consider delegated sign off of investigations but must ensure that robust arrangements are in place for Board overview.

   In Place, currently all Serious Adverse Incidents are reported to Board. Concerns Panel also established.

11. Do not automatically suspend the investigation process if legal proceedings are commenced but work in conjunction with external agencies to ensure that local learning is not lost and that the duty of care to others is met.

   Being implemented.

12. Consider the joint investigation of complaints in all cases where more than one organisation is involved (either more than one NHS organisation, or NHS/Local Authority, NHS/independent provider) to ensure that the patient has all aspects of the complaint answered in a joint investigation.

   Being implemented in partnership with NHS Wales colleagues.

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**Primary Care**

15. Ensure that any staff skills/training analysis includes the potential for the investigation of primary care complaints.

   Being factored into implementation arrangements.

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**Advocacy, Support and Facilitation**

16. Continue to encourage the use of advocacy and signpost to services provided by Community Health Councils and specialist advocacy.

   Implemented.

17. Consider the use of the Independent Complaints Facilitation Service in resolving concerns, if appropriate.

   In Place and on occasion Independent Complaints Facilitation Service has been accessed.

18. Put in place systems for supporting staff who are the subject of a concern, paying attention to many of the principles of good practice outlined in the interim guidance

   In Place.
In addition to the actions required of the UHB to respond to the new Regulations a number of other actions have also been progressed in the last six months. These include;

- All members of the Corporate concerns and patient safety team have received legal training in NHS Redress;
- 87 members of staff have had legal training in 5 workshop sessions on 3 hospital sites, further sessions are being arranged;
- An additional 70 multi disciplinary staff have been trained to undertake Root Cause Analysis based investigations (in excess of 300 staff trained in this over last 5 years);
- 15 awareness sessions have been arranged by the Concerns and Patient Safety team managers within Clinical Divisions / Directorates, further sessions are also arranged;
- 19 staff have been provided with the NPSA facilitated ‘Being Open’ training;
- The UHB is in the process of implementing and making generally available to staff an e-learning training package on the new Regulations. The Concerns Panel have mandated the requirement for all staff to receive training.

**RELATED CHALLENGES**

The central team have coordinated a significant amount of work to implement these arrangements within the UHB. In addition the corporate Patient Safety and Quality team has undertaken additional work to support staff and raise awareness of the requirements of the new Regulations.

The significant increase in the volume of concerns related activity experienced in quarter 1 this year, has proved challenging for the central teams and those Divisions receiving the majority of this increased activity.

The current Datix (database software) system, used to capture complaints, claims and patient safety incident activity, is not designed to respond fully to the new Regulations or the minimum data set recently issued by the Welsh Government. A number of meetings have taken place with colleagues from NHS Wales organisations, WG and Datix. However, no easy solution has been found and it would seem internal programming may be necessary in order for reports to be generated that meet the requirements of reporting against the new Regulations.
In addition arrangements relating to the recording and responding to the ‘no’ and ‘minor’ harm categories of staff reported patient safety incidents (the vast majority of reported incidents) are not yet being dealt with under the new Regulations, due primarily to limitations in capacity and directing resource to the incidents graded moderate to severe.

The Concerns Panel have recognised the significant additional requirements the new Regulations place on the UHB and have agreed that a pragmatic approach in responding to the new Regulations is necessary and appropriate. In addition the Panel have requested an assessment of additional resource necessary to fully implement all the requirements of the new Regulations.

The Welsh Government continue to holds its all Wales implementation group which the UHB is a member of. In October 2011, Welsh Government intend holding a review of progress across NHS Wales with implementation of the new Regulations and any related issues.

CONCLUSION

The changes outlined within the proposed regulations have resulted in significant adjustments in how the organisation manages and responds to ‘concerns’.

Good progress has been made in restructuring the Patient Safety and Quality department and aligning the requirements of the new Regulations under one department and one lead Executive. However, The corporate department continues to work with Divisions / Directorates and localities to coordinate the training and awareness campaign to ensure staff are fully trained to avoid concerns wherever possible and respond to them if raised. Issues outlined in the related challenges section of the report remain the focus for ongoing work within the UHB.

RECOMMENDATION

The Quality and Safety Committee is asked to:

- **NOTE** the content of this report.
## IMPACT ASSESSMENT

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Health Improvement</td>
<td>Designed to improve staff and patient experience by dealing with complaints, claims, and reported incidents in a comprehensive and consistent way.</td>
</tr>
<tr>
<td>Workforce</td>
<td>The proposed changes will lead to multi-skilled team working, and a more robust way of investigating issues raised by staff and patients. Further training and development will be a key part of the implementation of the changes.</td>
</tr>
<tr>
<td>Financial</td>
<td>The proposed changes will have a financial impact, this is being monitored by WG.</td>
</tr>
<tr>
<td>Legal</td>
<td>Redress will be a key part of the implementation of the new system, and the legal implications will be an integral part of this.</td>
</tr>
<tr>
<td>Equality</td>
<td>The new system will further promote a system which is fair and equitable for all.</td>
</tr>
<tr>
<td>Environmental</td>
<td>There are no environmental impacts</td>
</tr>
</tbody>
</table>

## RISK ASSESSMENT

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Clinical/Service</td>
<td>This report provides an update on the measures proposed to implement the new Regulations and outlines some areas where challenges remain, not least in the increased volume of activity.</td>
</tr>
<tr>
<td>Financial</td>
<td>Failure to implement fully the related Regulations will impact financially on the UHB. Even fully implementing the Regulations is likely to result in an increase in NHS Redress related expenditure.</td>
</tr>
<tr>
<td>Reputational</td>
<td>Loss of public confidence should the new Regulations not be implemented and concerns actioned appropriately.</td>
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</tbody>
</table>
CONSULTATION AND ENGAGEMENT

Ongoing engagement with Clinical Divisions and Clinical Directorates to inform implementation of the new Regulations

SOURCES OF INFORMATION & EVIDENCE

Putting Things Right
- Dealing with Concerns toolkit

How to deal with concerns raised about the NHS from 1 April 2011

www.puttingthingsright.wales.nhs.uk
**Dealing With Concerns Toolkit**

This toolkit has been developed to provide a clear overview of how concerns are managed by the NHS in Wales under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. The flowcharts are designed to provide a high level representation of how the arrangements should work.

For more comprehensive details about the management of concerns, please see the full Guidance issued to the NHS in Wales at the end of March 2011.

The Guidance which interprets the Regulations, and other useful resources such as patient leaflets, posters, and model letters, are available at:

[www.puttingthingsright.wales.nhs.uk](http://www.puttingthingsright.wales.nhs.uk)

Thank you.
Important phrases to note

The phrases used in the flowcharts have the following meanings:

“Responsible Body”
is defined as a Welsh NHS body, a primary care provider or an independent provider.

“Welsh NHS body”
is defined as a local health board or NHS trust managing a hospital or other establishment or a facility wholly or mainly in Wales.

“Primary care provider”
is defined fully in the Regulations and essentially covers general practitioners; dentists; persons providing ophthalmic services and pharmacists who provide services under arrangements with local health boards.

“Independent provider”
means a person or body who (a) provides health care in Wales under arrangements with a Welsh NHS body and (b) is not an NHS body or a primary care provider.

“Qualifying liability in tort”
is where a Welsh NHS body has BOTH (1) failed in its duty of care to a patient, and that the breach of duty of care has been (2) causative of the harm that the person has suffered. It is only when both these tests are satisfied that a payment of compensation under the Regulations should be considered.

“Limitation period”
is the time normally allowed to bring a claim in law - usually three years from the date of the treatment or three years from the date the person became aware of the matter.
Anyone can raise a concern with a member of staff who will, if possible, try to resolve the concern there and then.

Concerns raised “on the spot” and resolved within the timescale agreed with the patient/representative when the concern was raised (ideally within 24 hours) are not handled under the Regulations, but should be recorded in line with local arrangements.

Any other concerns should be raised under the Regulations.

Start with Chart A2 and follow the charts according to the concern.
Chart A2: How the NHS deals with a concern raised and dealt with under the Regulations

1. Concern is raised with the LHB or Trust (either by patient/representative following a negative experience or by staff member if a patient safety incident).

2. Acknowledge concern within 2 working days of receipt, seek consent if appropriate and establish any needs or support requirements.

If harm has been alleged, consider whether there is, or may be, the possibility of a qualifying liability in tort, follow Chart C.

3. Investigate concern in accordance with Regulation 23.

4. Issue a final response under Regulation 24 within 30 working days of receipt of concern, if there is no qualifying liability in tort.

5. Advise person of their right to contact the Public Services Ombudsman for Wales after the above stages.
Acknowledge concern within 2 working days of receipt, seek consent if appropriate and establish any needs or support requirements.

1. Concern is raised with the primary care provider (either by patient/representative following a negative experience or by staff member if a patient safety incident).

2. Acknowledge concern within 2 working days of receipt, seek consent if appropriate and establish any needs or support requirements.

3. Investigate concern in accordance with Regulation 23.

4. Issue a final response under Regulation 24 within 30 working days of receipt of concern.

5. Advise person of their right to contact the Public Services Ombudsman for Wales after the above stages.

If concern is raised by a person with a Local Health Board about a primary care provider, follow Chart B1.

If a primary care provider asks a LHB to investigate a concern on their behalf, follow Chart B2.
Within 2 working days of receipt of concern, LHB to contact individual to obtain their consent to the LHB contacting the primary care provider and to see whether they have already responded.

If consent given and primary care provider has not already responded, LHB to determine whether it will investigate within 5 working days of receiving the above information. If no consent given LHB cannot investigate unless it is a very serious issue of patient safety.

If primary care provider has already responded, LHB cannot investigate again.

If LHB decides it is more appropriate for the primary care provider to investigate then the person must be advised of this and advised that they should raise their concern with the practice directly, and the practice must then investigate.

LHB to inform person of their right to take concern to Public Services Ombudsman if LHB decides not to investigate.

If person goes on to raise the concern with the primary care provider they must investigate in accordance with the Regulations and still issue a response within 30 working days of receipt by the LHB.

If LHB decides to investigate it should continue to deal with the concern in accordance with the Regulations and LHB issues a response within 30 working days of receipt of the concern. LHB follows Chart A2.
1. Within 2 working days of being asked to investigate, LHB to check with primary care provider whether the person has given their consent to LHB investigating, and to see whether the primary care provider has already responded.

2. If consent given and primary care provider has not already responded, LHB to determine whether it will investigate within 5 working days of receiving the above information. If no consent given LHB cannot investigate, the primary care provider must investigate.

3. If the primary care provider has already responded, LHB cannot investigate again.

4. If the LHB decides it is more appropriate for the primary care provider to investigate, then the primary care provider must be advised of this.

5A. The primary care provider must investigate in accordance with the Regulations and issue a response within 30 working days of first receipt. Primary care provider follows Chart A3.

5B. If LHB decides to investigate it should continue to deal with the concern in accordance with the Regulations and LHB issues a response within 30 working days of receipt of the concern. LHB follows Chart A2.
If ‘Yes’ then the Redress arrangements cannot be used (please refer to Guidance).

1. Concern is raised which contains an allegation of harm.

2. Is there a possibility of any qualifying liability in tort? (I.e. a breach of duty of care and that this has been causative of harm).

3. Do the facts of the case lead to the conclusion that the £25,000 limit would be exceeded?

4. If ‘No’ then Welsh NHS body to continue to determine whether there is, or may be, a qualifying liability in tort.

5. Draw up the questions which need to be addressed, in order to decide if there has been a breach of duty of care/cause - If necessary secure independent expert opinion to answer the questions.

6. If it is determined that there is no qualifying liability in tort, then Welsh NHS body to complete investigation and issue a final response under Regulation 24, within 30 working days of first receiving the concern.

7. If it is determined that there is or may be a qualifying liability in tort, then Welsh NHS body issues an interim response under Regulation 26 within 30 working days of first receiving the concern.

8. Then follow Chart D.
Investigation commences under Part 6 of the Regulations (Redress), advise person they are entitled to free legal advice. The limitation period is suspended from the date the concern was first received by the Welsh NHS body. Redress might include an apology, report, explanation, financial compensation and/or remedial treatment - Remember £25,000 financial limit cannot be exceeded.

Obtain Compensation Recovery Certificate in respect of any state benefits claimed and obtain evidence of any monetary loss the person may be claiming (e.g. loss of earnings; costs of care and assistance).

Welsh NHS body to ascertain (if not already done so earlier) whether there has been a breach of duty of care and causation. Consider whether any further expert reports are required on any outstanding questions - if person has accepted offer of free legal advice, their legal adviser should be allowed input into the instruction of experts.

If qualifying liability in tort is admitted, proceed to quantifying claim and drawing up an offer - use tariff and/or commission independent advice on quantum. Communicate decision to person, if they have accepted offer of free legal advice, send copies of offer and all evidence to their legal adviser.

If qualifying liability in tort is not admitted, communicate decision to person, and if they have accepted offer of free legal advice, send copies of offer and all evidence to their legal adviser.

For both options 5A and 5B: Decision to be issued within twelve months of the first receipt of the concern. Person has six months to respond to the offer.