Reference Number: UHB 332 **Version Number:** 3	**Date of Next Review: 26 January 2026** **Reference Number:** T/3

Concerns (Complaints) and Claims (Clinical Negligence, Personal Injury and Redress) Management Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will manage all concerns/claims in accordance with the policy.

Policy Commitment

To provide a transparent, equitable and proactive approach to the management of concerns (Complaints and Claims) to ensure that learning is identified and actioned at the earliest opportunity**.**

Supporting Procedures and Written Control Documents
Other supporting documents are:

Responsibilities & Accountability Framework

Scheme of Delegation

Claims Handling Escalation Procedure
Standing Orders and Standing Financial Instructions

WHC (97) 17 - CN & PI : Claims Handling

WHC (97) 7 - CN & PI: Structured Settlements

WHC (98) 8 – NHS Indemnity – Arrangements for Handling CN Claims against NHS staff

WHC (99) 128 – Handling CN Claims: Pre-Action Protocol

WRP Claims Management Standards (April 2007)

WRP Reimbursement Procedure & other Procedures

Civil Procedure Rules 1998

Putting Things Right Regulations 2011 (Guidance amended November 2013)
Public Service Ombudsman Model Complaints Handling Policy

Scope

This policy applies to all of our staff in all locations including those with honorary contracts

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has / has been completed and this found there to be a positive. No key actions have been identified

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Patient Experience-Concerns Department

Summary of reviews/amendments

Addition of the updated Welsh Risk Pool Reimbursement Process
Public Service Ombudsman Model Complaints Handling Policy

Review of the regulations and legislation

Version Number	Date Review Approved	Date Published
1	13/09/2016	11/10/2016
2	*18/12/2020*	*tbc*
3	*26/01/2023*	*06/03/2023*

1. POLICY STATEMENT

1.1 This document describes the Policy of the Cardiff and Vale University Health Board for the management of concerns (Complaints and Claims) made against the Health Board.

1.2 Both the human costs of things going wrong and the financial costs of providing redress are powerful incentives for effective risk management. It is acknowledged that funds that are spent on addressing and compensating could otherwise contribute to the continuous improvements of healthcare services and working environments. Therefore, this Policy forms an integral part of the Health Board's Risk Management Strategy and is intrinsically linked into the Health Board's systems for managing and learning from adverse incidents and complaints.

1.3 The Health Board aims to deal with all concerns made against it proactively, in an equitable, efficient and timely manner.

1.4 The Health Board will adopt a common and standardised approach in dealing with complaints, litigation claims for both clinical negligence and personal injury. The Health Board aims to gather all evidence as quickly as possible and, where liability is admitted, will seek to negotiate settlement in the shortest possible time therefore minimising unnecessary legal costs.

For complaints refer to appendix A for process

Claims

1.5 The Health Board will defend claims where appropriate. It will make every effort to resolve a claim before the issue of court proceedings and will explore the option of alternative dispute resolution methods when appropriate. However, where formal legal action or Court proceedings is required the Health Board will ensure that it conducts its defence of the Claim in a fair and timely manner, ensuring that legal costs are incurred appropriately and proportionately.

1.6 The Health Board acknowledges the importance of the claims management process within its organisation and will ensure that the process is supported by a robust escalation policy. The weekly executive meetings enable the timely consideration of identified legal cases.

1.7 The Health Board will comply with the Pre-Action Protocols laid down by the Civil Procedure Rules in dealing with all legal claims ensuring a constructive and open approach to claims that reduces delays and costs and the need for formal legal proceedings.

1.8 The Health Board is committed to learning lessons from claims to ensure the continued improvement in standards of patient and staff safety and services.

2. INTRODUCTION

2.1 This Policy has been produced in accordance with the references contained in Appendix 1 for the management of the following:

- clinical/medical negligence claims;
- personal injury claims;
- Redress claims

It does not cover Employment or Estates issues.

2.2 The Health Board has a legal duty of care towards those it treats, together with members of the general public and its staff. People who consider they have suffered harm from a breach of this duty can make a claim for compensation and damages against the Health Board.

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

- that he/she was owed a duty of care;

- that the duty was breached;
- that the breach of duty caused, or contributed materially to, the damage in question; and
- that there were consequences and effects of the damage.

2.4 The Limitation Act 1980 requires that claims be made within three years of the date of the incident or three years from the date a claimant became aware that he/she had suffered from an episode of negligence. With minors, the three-year limitation period becomes effective once they have reached the age of 18. However, there are no time limits for people with a disability who cannot manage their own affairs. Claims exceeding the three-year limitation period can, however, still be brought against the Health Board at the discretion of the Court or by prior agreement to a moratorium of the three year limitation period

3. DEFINITIONS

The following provide definitions for clinical negligence, personal injury.

3.1 Clinical/ Medical Negligence

"A breach of duty of care by members of the health care professions employed by NHS bodies or by others consequent on decisions or judgments made by members of those professions acting in their professional capacity in the course of employment, and which are admitted as negligent by the employer or are determined as such through the legal process."

3.2 Personal Injury

"Any disease or impairment of a person's physical or mental condition."

4. RESPONSIBILITIES

4.1 The Chief Executive is the Board member with overall responsibility for issues relating to clinical negligence and personal injury and for keeping the Health Board informed of major developments. This responsibility has been delegated to the Executive Director of Nursing.

4.2 All Executive Directors and Clinical Board Directors, Directors of Nursing and Directors of Operations have delegated accountability and responsibility within their designated areas for the implementation and adherence to this policy.

4.3 The Concerns Managers are accountable to the Executive Nurse Director via the Assistant Director of Patient Experience for the management of claims for ensuring compliance with the policy, including compliance with delegated authority limits and for securing the most cost-effective resolution of claims.

4.5 All members of staff are encouraged to report adverse incidents, including those that may lead to claims for compensation, in line with the Health Board's promotion of a just, blame free culture and in line with the new duty of candour coming into force in 2023

4.6 Staff also have a duty towards the Health Board in the investigation and, where appropriate, defence of all claims and will assist all claims staff, as necessary during the claims management process.

4.7 Approval of this strategic Claims Management Policy will rest with the Health Board or delegated committee; although the approval of subsequent claims management procedures setting out the detailed operational arrangements for complying with this policy will be delegated by the Health Board to the appropriate committee.

5. DELEGATED LIMITS

Delegation of Out of Court Settlement

5.1 The Health Board acknowledges that the Welsh Assembly Government has delegated its responsibility for the settlement of claims to a limit of £1 million to the Health Board and that the Health Board continues to exercise this discretion subject to satisfaction with minimum requirements and standards:

- That it adopts a clear policy for the handling of claims which satisfies the requirements of WHC(97)17
- That the requirements of WHC(97)17 form the basis of the procedure for the day to day management of claims.

Internal Delegated Limits

5.2 The Health Board has formal delegated responsibility from the Welsh Assembly Government for the management of clinical negligence and personal injury claims valued up to £1 million.

5.3 The levels of delegated authority within the Health Board are those contained within the Health Board's Scheme of Delegation.

6. USE OF LEGAL ADVISORS

6.1 The Health Board will use legal advisors in the defence or settlement of significant clinical negligence and personal injury claims. Small to moderate value claims of modest complexity may be managed in-house by the Health Board's

Redress Team/Concerns/Claims Managers. The legal process of claims will be managed by NWSSP: Legal and Risk Services.

6.2 Where external legal advice is sought, the Health Board will retain the responsibility to direct its solicitors in respect of liability admission, defence, settlement and general strategy. However, the Health Board will always take due account of qualified legal advice in making such decisions. Legal advice will cover:

- Liability and causation; with the exception of some redress cases
- An assessment of the strength of the available defence and probability of success;
- The likely valuation of quantum of damages including best and worst case scenarios; and:
- Estimates of legal costs for claimant and defendant

6.3 For claims managed in-house, advice will be provided by the Health Board's Concerns Managers. In all such cases, advice will be recorded on the case file satisfying the same requirements for the provision of legal advice as are set out in paragraph 6.2 above.

6.4 The decision to settle a claim or to continue with its defence will be on the basis of legal advice of Counsel and/or Legal and Risk Services, in conjunction with Concerns Managers.

7. THE ROLE OF THE CONCERNS/ CLAIMS MANAGERS

7.1 The Health Board will employ dedicated Concerns Managers, who can demonstrate sufficient experience in the management of Clinical Negligence and Personal Injury claims.

7.2 The Concerns Managers will be required to demonstrate on-going updating and continuing professional development in the area of claims management.

7.3 There must be demonstrable communications, as necessary to achieve the objectives of WHC(97)17 for effective claims management.

7.4 The Concerns Managers will ensure that all members of staff and/or their line managers involved in a claim are kept informed of the progress and outcome of the claim.

8. REPORTING REQUIREMENTS

8.1 The Health Board delegates its responsibilities to the Concerns, Claims and Compliments assurance group, the duly authorised committee. The group will receive and review quarterly progress reports on the management and status of claims against the Health Board, in the format specified by WHC (97)17.

8.2 The delegated committee will receive a quarterly report, reporting upon comparative issues.

8.3 The Terms of Reference of the delegated committee as the duly authorised Committee will reflect its role in relation to claims.

8.4 The Executive Nurse Director retains responsibility for claims management within the Health Board and will ensure that the Health Board is kept informed of significant and major developments.

8.5 It is acknowledged that where a claim has been identified as a Patient Safety Incident but that it was not previously reported through the incident reporting process, the Health Board will ensure that a procedure exists which is set out in the Claims Management Written Control Document, to support the objective that the person with responsibility for Risk Management within the Health Board, is informed, and a retrospective report is sent to the National Patient Safety Agency by the National Reporting and Learning System as appropriate following a review.

8.6 The reporting requirements relating to the reimbursement process managed by the Welsh Risk Pool

8.7 The reporting requirements to the Welsh Assembly Government are set out in this policy.

9. CLAIMS MANAGEMENT WRITTEN CONTROL DOCUMENT

9.1 The Health Board will ensure that a Claims Management Written Control Document is developed which supports and embraces the objectives contained in this Policy and WHC(91)17.

10. INVOLVEMENT OF STAFF

10.1 The Health Board recognises that the co-operation of all staff involved in the incident leading to a claim is crucial to the early collation of information to that case. The Health Board will ensure that staff are encouraged to support the Concerns Managers and any duly appointed legal advisors, in the handling of that claim. All staff are required to fully and openly co-operate with the investigation of any legal

claims and to comply with this Policy and the Claims Management Written Control Document.

10.2 Once a claim has been received, the Concerns Managers will establish an objective account of the original incident at the earliest available opportunity.

10.3 Unless there are exceptional circumstances, any member of staff asked to do so should provide the Concerns Managers with a witness statement and information regarding the investigation of the relevant claim in a timely manner.

10.4 The Health Board recognises that providing a statement and giving evidence can be a stressful experience and will ensure that full support and guidance is provided to members of staff who are asked to give evidence on behalf of the Health Board.

10.5 The Health Board will support an escalation procedure to be contained in the Health Board's Claims Management Written Control Document to secure this objective.

10.6 The Health Board will take full responsibility for managing and, where appropriate, settling claims in clinical negligence cases, meeting all its financial obligations and will not seek to recover any costs from health professionals. In very exceptional cases, where the health professional was legally found to be acting outside of his/her remit, the matter will be referred to the appropriate Clinical Board or Executive Director.

11. NUISANCE CLAIMS

11.1 The Health Board will not settle claims of doubtful merit, however small, purely on a 'nuisance' value basis. Similarly claims will not be inappropriately defended.

11.2 The decision to settle a claim will always be based upon an assessment of the Health Board's legal liability and the risks and costs associated with the defence of that claim, including the prospects of recovering those costs in the event that the defence is successful.

12. REPORTING OF CLAIMS TO WELSH ASSEMBLY GOVERNMENT

12.1 **Novel, Contentious or Repercussive Claims**

The Concerns Managers will monitor the nature and type of claims received to highlight any claims which are considered to be novel, contentious or repercussive.

In such cases the Concerns Managers will liaise with the designated Solicitors/Legal Advisors, to ensure that the Welsh Assembly Government are duly made aware or advised. The Director of Governance and Communications will be kept informed throughout.

12.2 **Claims Exceeding the Delegated Authority**

The Concerns Managers will ensure that any claims with damages estimated to exceed the Health Board's delegated authority of £1 million are reported to the Welsh Assembly Government and prior approval is obtained in advance of liability being conceded and the claim being settled.

12.3 The Annex form will be signed by the Clinical Board lead, Executive Nurse Director and /or Chief Executive prior to the matter being reported to the Welsh Assembly Government and a copy will be presented to the Quality and Safety Committee for information purposes only.

13. DATABASES

13.1 The Health Board will maintain a Claims Handling database via datix :

- The Health Board's claims data-base will contain the information given in the Claims Management Written Control Document. All Clinical Negligence and Personal Injury claims will be entered onto the database by the Legal Services Manager or by an authorised member of staff.

- The Health Board will ensure that patient and staff confidentiality is maintained.

14. LINKS BETWEEN CLAIMS, COMPLAINTS, INCIDENTS AND OTHER RISK INFORMATION

14.1 The Health Board recognises the need for close connections between risk management, complaints, incidents and the management of claims. It appreciates the need for close and co-operative working between these functions and will ensure that appropriate linkages are in place to facilitate this objective.

Linkages

14.2 Adverse incidents or outcomes which could lead to a claim for negligence should be identified and reported to the Concerns Managers at the earliest possible opportunity, either through the provision of a serious incident report sent to the Welsh Assembly Government or Regional Office or by the provision of the relevant documentation.

14.3 The Concerns Managers will work together to identify complaints which involved potential breaches of the legal duty of care by the Health Board. An appropriate investigation will be undertaken to enable the Health Board to adopt a pro-active stance to the management and resolution of potential claims identified through the complaints procedure. Never events will be discussed with the concerns team to establish if redress is appropriate for early and effective litigation resolution.

14.4 Appropriate systems will be established by the appointed deputy, to enable the lead members of staff for complaints, risk and claims to meet on a regular basis through an appropriate forum to ensure the identification of any trends and remedial action that may be required. Appropriate and relevant staff will then implement any recommendations arising from complaints, claims, experts' reports and investigations.

14.5 The Claims Handling Database system identifies where a potential claim has previously been reported as an incident or complaint. This facilitates the gathering of information to comply with the relevant Pre-Action Protocols.

Committee Structure

14.6 Summaries of claims and trends will be routinely provided for information and management action as necessary to such committees as requested.

14.7 The special losses panel will routinely report the value and incidence of Claims, payments to the Audit Committee.

Controls Assurance

14.8 The Concerns Managers are the Lead Officers for the Welsh Risk Management Standard for Claims Management and are responsible for provision of the evidence against this standard which relates to matters within their jurisdiction.

15. LEARNING LESSONS FROM CLAIMS AND IDENTIFYING CLAIMS FROM INCIDENTS AND COMPLAINTS

15.1 The Health Board is committed to learning lessons from claims, complaints and adverse incidents.

15.2 It is important that wherever possible lessons are learnt following an incident. It is the responsibility of Concerns manger to ensure that any lessons learnt from claims are communicated to the relevant staff in the Clinical Board structure and that any action plans are implemented and monitored in a timely manner.

15.3 The Health Board, via the Clinical Boards, will ensure that a formal process and procedure to support the learning of lessons, monitoring of implementation of lessons learned, evaluation of the efficacy of lessons learned and thereafter the auditing of each component, is developed.

15.4 The Concerns Managers will identify the potential for 'learning lessons' from claims. This information will be routinely reported to the appropriate committee in accordance with the formal procedure for learning lessons as set out in the Claims Management Written Control Document.

15.5 The Concerns Managers will identify the potential for the use of alternative dispute resolution before considering litigation. In addition, the established NHS Complaint's procedure will be used to ensure that patients receive, where appropriate, an apology and a full explanation of what went wrong to reduce the potential for complainants to take legal action to achieve such a remedy.

15.6 The Concerns Managers will produce an Annex form Checklist and an associated Action Plan for all claims exceeding the Health Board's excess of £25,000. This will be used as the basis for learning, monitoring and evaluating the efficacy of the lessons learned from claims.

16. LIAISON WITH THE WELSH RISK POOL

16.1 The Health Board is assessed annually against the Welsh Risk Pool Standard for Claims Management.

16.2 The Health Board will comply with the various rules and procedures of the Welsh Risk Pool. The Concerns Managers will ensure the Health Board's adherence to the same.

16.3 The Concerns Managers will report details of claims settled with a quantum of under £25,000 to the Welsh Risk Pool using the LFER (Learning from events report) form or such other format as may be required by the Welsh Risk Pool. For matters of Redress, all matters where a qualifying liability has been established a LFER will be due, regardless of quantum.

16.4 In order to be reimbursed by the Welsh Risk Pool, the Health Board is required to submit a CMR (case management report), Costs Schedule and Annex form Checklist, in a format consistent with that set out in the Welsh Risk Pool reimbursement procedures.

16.5 The Health Board acknowledges that the Welsh Risk Pool will periodically undertake reviews of claims managed by the Health Board. The Health Board will ensure the co-operation of its members of staff with such reviews through the development of a formal review process to be contained in the Claims Management Procedure.

17. NHS REDRESS ACT 2006

17.1 The Health Board appreciates and is committed to the objectives of the NHS Redress Act 2006 which provides for the development of a small value clinical negligence scheme for Wales.

17.2 The Health Board will undertake such action as it deems appropriate to support the introduction of such a scheme following the development of detailed regulations and which will be included in its Claims Management Procedure.

REFERENCES

This Policy complies with the following references:-

- The Civil Procedure Rules 1998
- WHC(97) 7 – Clinical Negligence and Personal Injury Litigation: Structured Settlements
- WHC(97)17 – Clinical Negligence and Personal Injury Litigation: Claims Handling
- WHC(98)8 - NHS Indemnity – Arrangements for Handling Clinical Negligence Claims against NHS Staff
- WHC(99)128 – Handling Clinical Negligence Claims: Pre-Action Protocol
- The Welsh Risk Pool Claims Management Standard (April 2007)
- The Welsh Risk Pool Reimbursement Procedure and other Procedures
- The Health Board's Standing Orders and Standing Financial Instructions

Documents to be read alongside this policy:

- UHB Claims Handling Statement of Intent
- UHB Claims Handling Policy & Procedure
- UHB Scheme of Delegation
- Claims Handling Escalation Procedure
- Standing Orders and Standing Claims Handling
- UHB Responsibilities & Accountability Framework
  Financial Instructions
- WHC (97) 17 - CN & PI : Claims Handling
- WHC (97)17 CN & PI: Structured Settlements
- WHC (98) 8 – NHS Indemnity – Arrangements for Handling CN Claims against NHS Staff
- WHC (99) 128 – Handling CN Claims: Pre-Action Protocol
- WRP Claims Management Standards (April 2007)
- WRP Reimbursement Procedure & other Procedures
- Civil Procedure Rules 1998

Review CLAIMS HANDLING PROCEDURE INDEX

1. PRE-LITIGATION PROCEDURE

1.1 Reporting and investigation of incidents (see Appendix 1: Flowchart – Claims Procedure)

The principal benefit of untoward incident reporting is that it provides a means of identifying claims at an early stage. In practice, years can pass between the date of medical treatment, giving rise to a claim or accident and a letter of claim, or a request for disclosure of medical notes and records. In the interim, key witnesses could have moved away or have little recollection of any particular case over and above the contents of a note or usual practice.

Early investigation into circumstances surrounding an alleged breach of duty is essential if the chances of successfully defending a claim are to be increased. In addition, work carried out at this stage is an investment if viewed as a means of identifying problem cases where an early conclusion would minimise legal costs.

Completion of the incident report should be undertaken as soon as practicable after the incident occurs and all the requisite documentation should be completed as comprehensively as possible, signed by the reporting officer and providing all relevant information and details of witnesses.

All witnesses should be asked to provide a statement to include those named in the incident report and other relevant parties. The manager should not simply rely on the names of witnesses given by the injured person but should make their own investigations to find out whether or not other witnesses exist. Brief statements should be taken from the witnesses and should include details of the witnesses name, address and job description and all information relevant to the allegation. There should be an investigation of the site of the incident, for example in slipping/tripping cases the location of the incident should be considered along with the floor surface or ground in question. Investigations should be carried out as to

whether or not there have been previous incidents or complaints and consideration should be given to obtaining photographs of the area at an early stage.

In relation to manual handling claims or incidents the risk assessment, injured persons training record and availability of other staff to assist with the manoeuvre should be obtained and considered. Particular note should be made of exactly who was on duty at the time and who could have been contacted.

The patient's details should be considered if injury were caused as a result of lifting or assisting a patient, with details of the patient's dependency level at the time of the incident should also be considered.

Consideration should be given to any possible element of contributory negligence on the part of the injured person.

The Concerns Manager should be notified immediately of any reported incidents or complaints that could potentially result in a claim.

2. DEFINITIONS

2.1 Timescale for bringing a claim

A patient contemplating an action must act relatively promptly. The general rule is that all actions for clinical negligence or personal injury must be brought within three years of the infliction of the relevant injury or the date of knowledge of the injury.

This is known as the limitation period and is laid down in the Limitation Act l990. In the case of a minor the three-year period runs from the date that the child attains the age of l8. The claimant must demonstrate that it is more likely than not that his or her deterioration in health or the injury complained of, resulted from the negligence of the defendant.

2.2 Clinical Negligence

Clinical negligence is defined by the Welsh Risk Pool (hereinafter referred to as the WRP) as: -

"A breach of duty of care by members of the Healthcare Professions (including medical practitioners, nurses and midwifes, professions allied to medicine, laboratory staff and relevant technicians) or by others consequent on decisions of judgments made by members of those professions acting in their professional capacity on relevant work, and which are admitted as negligent by the employer or are determined as such through the legal process."

In as much as a breach of duty of care is alleged, the Health Board will need to seek legal advice in individual cases. In general terms however, the following must apply before liability for negligence exists: -

- There must have been a duty of care owed to the patient by the relevant professional(s)
- The standard of care appropriate to such duty must not have been attained and therefore the duty breached whether by action or inaction, advice given or failure to advise
- It must be demonstrated that the breach caused the injury and therefore the resulting loss about which the patient complains
- The loss must have been reasonably foreseeable

2.2.1 Private work

Consultants providing care under private arrangements with their patients, or Consultants or other clinical staff treating patients in connection with voluntary work or "Good Samaritan" act, are not covered by these arrangements or the WRP. Instead, consultants or other clinical staff should take out their own medical defence insurance. However, the WRP cover does apply where medical or other staff working under their NHS contract provide care for a consultant's private patients.

Any incident arising as a result of private work, which involves other staff, facilities or equipment, must be reported in the usual way.

2.3 Personal injury

Personal injury litigation can be defined as action taken (often through solicitors) by an individual who has sustained an accident or contracted a condition as a consequence of alleged exposure to a harmful substance and **not** as a result of clinical intervention, treatment or lack of treatment. The Health Board receives such claims from staff, visitors and patients who have suffered an injury related to the premises. The majority of cases brought against the Health Board are union funded and the union solicitors will inevitably advise the claimants. In the absence of legal advice a claimant can of course bring a claim without legal assistance, known as a 'litigant in person'. This occurs rarely. For the purpose of this document, reference will be made to claimants who are being represented by solicitors. Not every incident gives rise to litigation, but for those incidents that do, it is essential that the Health Board have in place a co-ordinated system that firstly examines issues of liability and causation which ultimately results in a claim being settled or defended. If the claimant is unable to adduce sufficient evidence to prove his or her case, a further possibility is that the claim may be discontinued.

To be successful, the claimant must prove, on the balance of probabilities (i.e.>51%) the following three things:

- That the Health Board had a duty of care to staff, visitors or patients to ensure that every precaution is taken to prevent personal injury
- That the duty of care had been breached by not complying with any standards set to safeguard the person

- That the breach of duty caused the damage to the person

2.4 Pre Action Protocols

The claimant or his/her solicitors should provide full details of the intended claim pursuant to the Pre Action Protocols contained in the Civil Procedure Rules, which arose from Lord Wolf's Access to Justice Report (July 1996). The Pre-Action Protocols were introduced on all proceedings that commenced after 26 April 1999 and impose challenging targets for the Health Board. The only way to avoid increased litigation costs and court imposed financial penalties is to ensure that a clear view about any alleged incident is reached quickly and effectively. This requires commitment from all staff involved to report adverse incidents and to respond quickly and clearly to allegations.

A detailed response to the letter of claim must be given within 4 months. These Protocols encourage early exchange of and full information to be given about a claim, with a view to trying to avoid litigation by agreeing a settlement before the commencement of proceedings. If the claim cannot be agreed, proceedings are issued and a claim form and particulars of claim are served upon the Health Board (unless an extension is agreed for service of the particulars of claim). This document sets out the details of the allegations against the defendant/Health Board, together with a medical report as to the claimant's condition and statement (or schedule) of special damages (financial loss said to have been suffered as a consequence of injury and future losses). The Protocols support efficient management of proceedings where litigation cannot be avoided.

2.5 Methods of reaching a settlement

Every effort should be made to discuss and negotiate settlement prior to court proceedings. This may include:

- Mediation/face to face discussion with the claimant regarding the claim
- Early evaluation of the claim by legal expert
- Internal arbitration
- Determination by an expert
- Alternative Dispute Resolution

3. HANDLING CLINICAL NEGLIGENCE CLAIMS

3.1 Notification of a claim

There are several ways in which the Health Board may be notified of a claim:

- Letter of claim
- Letter of Notification
- Request for medical records from a solicitor where it is stated that action against the Health Board is contemplated
- Verbal

- During the complaints process
- Direct contact

3.2 **Initial stage of the claim**

When notification of a claim is received, usually in the form of a letter of claim, and it is stated that there is a potential or actual threat of litigation as a result of negligence; certain action will then need to be undertaken immediately. An assessment of the claim is required to ascertain what information will be required.

The claim will be acknowledged in an appropriate manner within 14 days, using the standard form letter available for use at the relevant time. The Health Board's solicitors are also notified, and formally requested to act on behalf of the Health Board, usually by sending to them a copy of the letter of claim.

3.3 First steps

Upon receipt of the claim for compensation, the details must be entered onto the Claims database. The database is the Health Board's own record of new and ongoing claims and must be maintained and updated throughout the life of the claim.

The following information is recorded:

- Name of claimant
- Name of second person, if the claim is on behalf of a child or patient who has died
- Unique reference number
- Type of claim
- Whether it is a Health Board or Health Authority claim
- Whether the claim has previously been the subject of an internal complaint
- Whether a clinical adverse incident form was completed at the time of the event
- Date of incident
- Date of letter of claim
- Directorate and specialty
- Ward or department
- Consultant
- Other Consultant or named staff
- Allegations
- Injury sustained
- Claimant's Solicitors
- Stage of the claim
- Quantum damages
- Quantum costs
- Compensation recovery unit
- Estimated date of settlement
- Compensation paid including interim payments

- Actual costs - claimant and defendant
- Additional costs

The former Health Authorities were abolished on the 31st March 2003. Powys Local Health Board has responsibility for accounting for the residual liabilities arising from legal claims against the former Health Authorities. Management is directly by the WRP on behalf of Powys HB.

Any queries in relation to these procedures should be directed either to the WRP's Senior Claims Support Officer or Finance Development Officer.

A file is then created to keep the documentation relevant to the claim such as:

- Correspondence to/from the Health Board's solicitors
- Risk management issues
- Copies of proceedings and expert opinions
- Witness statements
- Internal correspondence
- Financial documents

3.4 Information required at the start of the claim
The standard information required at the start of the claim and the reasons for this, are detailed below:

a) Full names and titles of all staff involved
It is useful at the outset if the consultant/manager in charge of the patient's care can list the staff involved so that statements can be obtained from all necessary parties.

b) Identity of the Doctors' defence organisations and membership numbers
Doctors no longer need to subscribe to a recognised defence organisation following the guidance given in circular WHC (89) 70. However, many doctors still pay a lower rate subscription to a defence organisation for personal advice. It is often found that the junior medical staff involved in treatment, which is later the subject of a legal claim, are no longer in post. If the Health Board has no forwarding address, the defence organisation can be engaged to locate Doctors and obtain statements when required.

c) Two copies of the case notes
When considering whether the claimant has a claim in respect of negligence, the patient and his legal advisors will clearly benefit by gaining access to the patient's notes, reports and X-rays and other test records. Disclosure of the records can be mutually beneficial to the other side and the Health Board, as a claim is often found to have no merit or an individual's actions may be exonerated. Money and effort can be saved by prompt disclosure.

Upon receipt of the medical records, the Concerns/Claims Managers shall check that the records are complete. Once copied, the notes shall be checked to ensure that the standard of photocopying is satisfactory and that the information is appropriate.
At the start of a claim, two copies of the claimant's case notes are required for use by the Health Board's solicitors - disclosure to the "other side's" solicitors (if an authority to disclose has been obtained) and for a nominated expert adviser. The copy notes should be made available within 40 days of the letter of claim, if practicable to do so.

Delays in the initial investigation of a claim are often caused by the poor standards of photocopied case notes, which are disclosed to the "other side", and criticism is often aimed at the presentation, clarity and format of copy case notes. It is therefore helpful if staff could ensure that they make comprehensive legible entries in the case notes, use a black pen at all times and ensure that case note sheets are filed in chronological order.

d) One copy of any relevant X-rays
X-rays form part of the medical records and are usually asked for in the list of documents requested from the claimant's solicitors. These will be disclosed through the Health Board's solicitors. Additional sets may be required depending on how many expert reports are commissioned.

e) View of the Consultant concerned upon the disclosure of the case notes to the other side's expert advisors
The Consultant will need to give his/her views upon the disclosure of case notes as soon as possible. If disclosure is not given promptly the claimant may apply for a court order requiring the Doctor or the Health Board to disclose any records or notes likely to be relevant in forthcoming proceedings under Section 33 of the Supreme Court Act l981 or under the Access to Health Records Act 1990 / Data Protection Act 1998. If an application is made for pre-action disclosure then additional costs may be incurred.

However, in view of the effects of the Access to Health Records Act 1990 / Data Protection Act 1998 and subsequent Welsh Assembly Government clarification, objections to disclosure of the case notes can only be made where there is something in the notes that could cause serious mental or physical harm to the patient or a third person, as defined in the relevant legislation.

f) Initial statements from the identified staff regarding their involvement in a claim
The Health Board will require co-operation if cases are to be defended. Statements will therefore be required to assist in investigating or defending a claim. Failure

without good cause to provide a statement could result in the Health Board being unable to defend an allegation of negligence.

At the start of each claim it is necessary that good preliminary reports be obtained from **all** the staff involved. Such statements, if adequate, provide invaluable information as to whether a claim has any foundation and its future management can be assessed. Until such statements are received it is difficult to proceed past the investigatory stage of a claim.

It is necessary, therefore, that the staff concerned, are informed of a claim as soon as possible and a copy of the claimant's solicitors letter outlining allegations is made available to them.

g) Member of staff with primary involvement

The member of staff who has primary involvement will need to be identified so that s/he can provide a detailed report.

h) Views of the clinical board as to whether he/she considers the claim to have any merit.

The Clinical Director and Consultant responsible for the patient should be informed about the claim by way of notice, with relevant documents attached. The Clinical Director and/or the Consultant will need to provide a preliminary report outlining the background of the case, involvement of his/her department as a whole, guidance on any areas of importance, identify the staff involved and finally offer any views as to whether the claim has any merit.

i) Any other background information

Any additional information available surrounding a legal claim, such as previous documentation at a complaints stage or untoward incident report should be considered.

3.5 Escalation procedure

Should the Concerns/Claims Managers encounter difficulties in obtaining comments from any members of the Health Board's staff, the matter shall be escalated to the attention of the, Clinical Board Director, Director of Nursing or Director of Operations If there is still difficulty in obtaining comments, the Concerns/Claims Managers will escalate matters initially to the assistant director of patient experience and ultimately the lead Executive will be informed.

3.6 Progress of the claim – expert advice

The claimant's claim will be reliant upon expert testimony to prove negligence. Expert medical evidence can be obtained to comment on many issues including causation, condition and prognosis and life expectancy. When a suitable expert has

been determined, the lead Clinician involved in the litigation claim will be invited to approve the appointment.

The Health Board may also wish to commission its own expert reports, particularly in relation to multi-track claims, which may lead to conflicting accounts as to the proper standard of care in the procedure in issue. In certain circumstances the Health Board may agree to the use of a joint expert. Given the complexity of clinical negligence claims, reports from Counsel are sometimes sought by the Health Board's legal advisors to consider the future management of the claim and to comment specifically on issues relating to liability and quantum.

The Clinical Board and lead Clinician shall be kept updated as to the progress of the claim at all times.

3.7 Assessment of the claim

An assessment of the claim will need to be made by the Concerns Manager and Health Board's solicitor, by examining expert legal and medical reports and the views of the staff involved. Although the views of the staff directly involved are considered, it is not appropriate that they are involved in the decision making process as this requires an independent role. These will need to be authorised by the concerns team staff, a second Executive Director, and Chief Executive.

Health Board approval will be sought as required. A broad guideline to the information usually required is:

- An objective account of the incident
- An explanation of the basis and background of the claim
- The views of the Welsh Government if the case involves novel, contentious or precedent setting issues
- A balanced view of the likely defence, including legal and medical opinion when available
- Clarification of the basis on which damages have been estimated
- A legal opinion of the likely outcome of any court hearing
- Assessment of quantum including, if applicable, the reason for the proposed settlement
- An estimate of the possible savings for the public purse if a payment is made
- Details of the proposed approach to negotiations with the claimant, including the initial offer and proposed upper limit
- Details, where applicable, of structured settlements/periodical payments
- Details of any systematic failings on the part of; the clinical or other front line staff, operational or risk management procedures, claims handling staff or claims handling procedures. If so, what action is intended to remedy the identified deficiencies, including the timetable for implementation of any

changes or improvements and identify how the proposed improvements will be monitored

3.8 Settle or defend

Upon receipt of the Health Board's instruction, the Health Board's solicitors will either prepare the case for Court or attempt to secure a settlement, which can either be accompanied by an admission of liability on a "without prejudice" basis.

4. HANDLING PERSONAL INJURY CLAIMS

4.1 Notification of a claim

There are several ways in which the Health Board may be notified of a claim:

- Letter of claim
- Verbal
- During the complaint process
- Direct contact

4.2 Initial stage of the claim

When notification of a claim is received, usually in the form of a letter of claim, and it is stated that there is a potential or actual threat of litigation as a result of an alleged breach of duty of care, then certain action will need to be undertaken immediately. An assessment of the claim is required to ascertain what information will be required. The claim will be acknowledged in an appropriate manner within 21 days, using the standard form letter available for use at the relevant time. The Health Board's solicitors are also notified, usually by sending to them a copy of the letter of claim.

4.3 First steps

Upon receipt of the claim for compensation, the details must be entered onto the claims database.

The database is the Health Board's own record of new and ongoing claims and must be maintained and updated throughout the life of the claim.

The following information is recorded:

- Name of claimant
- Name of second person if the claim is on behalf of a child or patient who has died
- Unique reference
- Type of claim
- Date of letter of claim
- Whether a clinical adverse incident form was completed at the time of the event

- Date of incident
- Date of letter of claim
- Department
- Location of incident
- Head of department
- Witness names
- Brief description of incident
- Injury sustained
- Claimant's solicitors
- Stage of the claim
- Quantum damages
- Quantum – claimant's and defendant's costs
- Compensation recovery unit
- Estimated date of settlement/closure
- Compensation paid including interim payments
- Actual costs - claimant and defendant
- Additional costs

A file is then created to keep the documentation relevant to the claim such as:

- Correspondence to/from our solicitor
- Risk management issues
- Copies of proceedings and expert opinions
- Witness statements
- Internal correspondence
- Financial documents

4.4 Action to be taken and information to be gathered

The standard action and information required at the start of the claim and the reasons for this are detailed below:

a) Notify the appropriate Clinical Board lead requesting, amongst other things:

- Incident documentation (report and check list)
- Accident book entry
- RIDDOR form
- Initial witness statements
- Documented training (if member of staff)
- Initial investigations
- Details of the patient (if involved)
- Photographs and plans
- Documentation re: repairs, staffing levels etc.
- Details of previous similar incidents
- Risk assessment
- Local procedures and protocol

- Personnel file (if member of staff)
- If the action concerns a member of staff, write to the Payroll Department, seeking details of the claimant's earnings and statutory sickness details
- Establish contact with the Head of Risk Management, seeking details as to any investigation or review undertaken in respect of the incident, establishing an objective account of the original incident, ascertaining the incident has been duly reported:
- Adverse Incident Report
- All meetings with complainants/Claimants can be audio recorded and a copy of the recording provided to all parties

Documentation to be accessed to include, but not limited to;

- Datix
- RIDDOR
- Ad Hoc Reports
- Risk Register

If not so reported, the Concerns/Claims Managers will link with the Risk Manager to ensure that a retrospective report is presented to the NPSA upon any and all Claims/Incidents as of 1st January 2004.

b) Notify the Compensation Recovery Unit, if the case is being dealt with internally.

c) Obtain Emergency Unit cards.

d) Ask the claimant to sign a form of authority for the release of his/her GP notes, Medical Notes, X-rays and Occupational Health Records

e) If the claimant's solicitors request copies of the A&E, hospital notes or X-rays, obtain the claimant's signed form of authority for the disclosure of these notes to the solicitors and check the quality and accuracy of the photocopied records before sending them to the solicitors (see 3.4.c).

f) Review the Directorate's response to the standard letter, payroll information and further information from the claimant's solicitors and obtain any further comments/statements required.

g) Establish an objective account of the original incident, which gives appropriate weight to the recollection of the staff originally involved.

h) At this stage, a decision will be made by the Executive Nurse Director or Concerns/Claims Managers regarding the handling of the claim internally or by reference of the file to one of the firms of solicitors duly appointed by the Health

Board. For the purpose of this document, reference will be made to the Health Board's solicitor.

4.5 Gathering the evidence

Staff should be aware that certain type of information is subject to confidentiality. In the past, statements have been received from staff, which makes reference to patients and their medical conditions. This is of course confidential to the patient.

In cases where staff have injured themselves when lifting a patient, it is usual for the claimant's solicitors to seek information in respect of the patient, normally the care plan, giving details as to weight and medical condition. The Health Board's legal **advisor** will ensure that any information will be subject to the removal of the patient's identification details thus anonymising the records.

It is a legal requirement, once legal action has been initiated, that we are bound to disclose any notes, memoranda etc. that relates to a specific incident that were in existence prior to the commencement of an action. It is therefore essential to instigate and maintain a system, which will ensure the ability to file and recall appropriate records.

The claimant's solicitors may request access to an area where their client allegedly sustained their accident. Whilst this request cannot normally be denied, it is important to place the request in the context of the proceedings. For example, if the Health Board's position in respect of liability and causation is a foregone conclusion in favour of the claimant then an inspection of the site in question would be an unnecessary addition to the costs of the action.

Where a site inspection has been agreed, the name of the appropriate contact officer should be given to the Concerns/Claims Managers or Health Board's solicitors, who will relay this information to the claimant's solicitors.

Should equipment be involved in an accident, this will have to be retained for inspection, if practicable, and if not, appropriate steps should be taken to provide a brief note as to its reason for disposal. Although not every accident leads to litigation, some incidents will prompt the senior manager responsible to ask for photographs to be taken, which of course will aid the Health Board, should the claim be initiated at a future date.

4.6 Expert evidence

Expert advice, such as engineer or medical evidence can be obtained to comment on many issues including liability, causation, condition and prognosis and life expectancy.

The Health Board may also wish to commission its own experts reports, particularly in relation to multi-track claims, which may lead to conflicting accounts as to the

proper standard of care in the procedure in issue. In certain circumstances the Health Board may agree to the use of a joint expert. Given the complexity of some claims, in particular clinical negligence claims, the Health Board's solicitors to consider the future management of the claim and to comment specifically on issues relating to liability and quantum and will seek advice from Counsel when appropriate. The Clinical Board shall be kept updated as to the progress of the claim at all times.

4.7 Assessment of a claim

Following the receipt of the evidence, the Health Board's solicitors will provide an initial assessment and valuation of the claim, together with recommendations for future management within four months of the notification of the claim if possible. Although the views of the staff directly involved are considered, it is not appropriate that they are involved in the decision making process. This requires an independent assessment of the available evidence and a consideration of the Health Board's position on the balance of probabilities.

The Health Board's solicitors will then prepare a summary of the claim by examining expert legal and medical reports and the views of the staff involved. A broad guideline as to the information usually required is:

- An objective account of the incident
- An explanation of the basis and background of the claim
- The views of the Welsh Government if the case involves novel, contentious or precedent setting issues
- A balanced view of the likely defence including legal and medical opinion when available
- Clarification of the basis on which damages have been estimated
- A legal opinion of the likely outcome of any court hearing
- An assessment of quantum including, where applicable, the reason for the proposed settlement
- An estimate of the possible savings for the public purse if a payment is made
- Details of the proposed approach to negotiations with the claimant (Including the initial offer and proposed upper limit)
- Details, where applicable, of structured settlement/periodical payments
- Details of any systematic failings on the part of clinical or other front line staff, operational and risk management procedures, claims handling staff, claims handling procedure. If so, what action is intended to remedy the identified deficiencies, including the timetable for implementation of any changes or improvements. It should also be identified how the proposed improvements will be monitored

4.8 Settle or defend

Depending on each individual case, the Health Board's Solicitor may be able to conclude the matter swiftly or else seek further expert opinion from suitably qualified

experts. If the Health Board's solicitors advise that the allegations cannot be defended, then authorisation for an out of court settlement will be sought within

delegated limits and agreed levels of authority. Alternatively, the Health Board's solicitors will prepare the case for court.

5. COURT PROCEEDINGS

Should court proceedings be commenced in relation to clinical negligence or personal injury claims, the Health Board's solicitors shall take the following actions:

5.1 The procedure

a) Claim form and particulars of claim

The claim form and particulars of claim will be served either directly on the Health Board or the Health Board's solicitors, together with the acknowledgment of service. The acknowledgement of service must be filed within 14 days, indicating whether the claim is to be defended. If the claim is to be defended a defence must be filed within 28 days of service of the particulars of claim.

Therefore, it is essential that any information requested is supplied promptly and forwarded without any unnecessary delays to the Concerns/Claims Managers for onward transmission to the Health Board's solicitors.

b) Development of a case

Court proceedings will be run in accordance with the Civil Procedure Rules and directions given for the conduct of the action at any Case Management Conferences.

c) Directions

- **Disclosure**

The parties to an action will have to serve Lists of Documents giving details of all documentary evidence relevant to the claim, not including those documents, which are privileged. Such documentation would include incident reports, risk assessments, claimant's training records, occupational health records etc.

- **Exchange of evidence**

The parties to the action will have to exchange witness evidence, to include lay witness and medical or other expert evidence prior to the trial.

Exchange of witness evidence is carried out on a simultaneous basis so each side receives the others evidence at the same time. The court at a Case Management Conference determines the time frame.

d) Trial/settlement

Following the completion of the above stages, the claimant will seek to push the matter towards trial, unless a decision is made by the Health Board to settle the

claimant's case or, on rare occasions, the claimant discontinues his/her action against the Health Board.

In readiness for the final hearing, the Concerns/Claims Managers shall arrange for the Health Board's witnesses to attend court and ensure that they have been briefed about court procedure.

The Health Board's position is determined after careful consideration of the evidence by the Health Board's solicitors, backed up by an opinion from Counsel, if necessary. The Health Board will request advice as to the likelihood of successfully arguing, on the balance of probabilities, that the Health Board was not liable for the claimant's injuries. At this stage it may be necessary to arrange a conference to include officers of the Health Board, usually the Concerns/Claims Managers, with the required level of Executive authority, the Health Board's legal advisors, experts, Counsel and witnesses in order to consider the available evidence and make a decision on the best options available to the Health Board.

Depending upon the level of quantum, the decision as to whether or not to proceed to trial or negotiate a settlement will be made by the Executive Nurse Director or the Board itself, depending on the level of delegated authority required. Upon receipt of the Health Board's instructions, the Health Board's solicitors will either prepare the case for final hearing or attempt to secure a settlement which can either be accompanied by an admission of liability or on a without prejudice basis. Once a decision is taken to settle a claim, the Health Board is committed to payment of those damages to the claimant, whether or not the Health Board admits liability.

On the advice of the Health Board's solicitors, the Health Board may wish to make a payment into court (Part 36 payment). This would protect the Health Board's position should the claim proceed to Trial.

6. CLAIMS HANDLING - GENERAL INFORMATION

6.1 The role of the Health Board's Solicitors

Once the Health Board's solicitors have been notified of a claim, they will then act on the Health Board's behalf in conducting the claim as set out above. They will keep in regular contact with the Concerns/Claims Managers and give an expert opinion of the strengths and weaknesses in the Health Board's defence. The solicitor shall also keep the Concerns/Claims Managers fully briefed on all stages of the claim throughout its lifetime.

6.2 Authorisation

a) To take certain action

Authorisation may be requested at any time during the life of a claim. This may be for:

- Authority to admit liability

- Authority to take certain action
- Authority to make an offer of settlement
- Authority to settle damages or costs for a certain amount

To obtain authority to take certain action, all the authorised signatories must sign an 'Authorisation Request Form' which is supported by evidence and then retained on the Health Board's claim file. All claims of £1 million and over have to be submitted to the Welsh Assembly Government for approval.

b) To make payments

Payments may be requested at any time during the life of a claim. These may include:

- Fees to expert witnesses
- Fees to Counsel
- Payments into court
- Interim/full and final settlements of the claimant's damages and costs
- Legal fees to the Health Board's solicitors (Personal Injury Cases)

A request for authority to make a payment is made on a 'Finance Request Form' to which the invoice/request for payment is attached. All the authorised signatories must sign this form. The form is then handed to the Finance Analyst who arranges for the cheque to be issued and then forwarded to the Concerns/Claims Managers for distribution. The Health Board's file must have a copy of the finance request form showing all required signatures.

6.3 Delegated financial limits

It is the responsibility of the Board to agree the circumstances, including delegated financial limits, in which various requests may be approved by authorised signatories being:

a) The Chief Executive,
b) The Board itself
c) The Executive Directors
d) Other

6.4 Structured settlements/periodical payments

At times, it may be appropriate for alternatives to a single lump sum payment to be considered.

In the event of a lump sum award, it is assumed that the claimant invests the money in a suitable mix of equities, gilts and cash and pays for the care costs out of these investments. These investments are subject to taxation and professional fees. A lump sum, prudently invested, will provide regular income for the claimant. However, there is also the possibility that the money awarded runs out before the claimant

dies. In this case it is assumed that the claimant falls back on the State who pays for their care costs although it is recognised that Free State care may not compare with that purchased by the claimant.

A structured settlement (which is a periodical payment funded by an annuity) is an alternative to a lump sum payment made to a claimant. A structured settlement involves a number of payments at different times in the future. The amount of money required at the present time to provide these payments in the future is known as the present value of the future payments. A structured settlement allows for part of the damages to be paid in the form of annual tax free instalments for the duration of the claimant's life.

The courts are now able to order structured settlements for future loss and care costs without the consent of the parties. It also gives the Lord Chancellor a power to enable such awards or agreements to be varied under specified circumstances, and prevents the assignment of the right to receive payments unless the court is satisfied that there are special circumstances, which make this necessary.

The structured settlement may be for the life of the claimant, for a specified period or of a specified number or minimum number or include payments of more than one of those descriptions. If the recipient of a structured settlement dies, the payments will cease. Therefore, there is a chance that the next payment may not be made. Each year, there is a chance that the recipient of the periodic payment could die. In high value claims a large proportion of the compensation is associated with future loss as a result of the injury. The Health Board will provide these payments either by means of an Annuity backed structured settlement or a self-funded structured settlement. Welsh Assembly Government guidance (WHC (97) 17) states that structured settlements must be considered for any settlement of £250,000 or more.

The Health Board will depend upon the guidance of its legal advisors and the finance department as to whether to enter into a structured settlement.
In the event that a structured settlement is considered/may be made, the Health Board should notify the WRP as soon as possible. This is essential as the WRP is responsible for setting up and maintaining the structured settlement schedule of payments once agreed by the Court. Once the claim has been settled and the Court has approved the structured settlement, the court order should be submitted to the WRP within 14 days of the order being approved.

Structured settlements are administered in the main by the Health Board's solicitors, Legal and Risk Services.

6.5 Quantum reports

On a quarterly basis the Concerns/Claims Managers shall prepare an up to date quantum report, which shall be forwarded to the WRP and to the finance department. The report will give quantum figures to enable the finance department to calculate

the Health Board's total liabilities and also probability of loss. The quantum may change during the course of the claim. The following information will also be noted by reference to the numbers 1-5.

Probability of loss

1 - 95%-100% certain
- The Health Board has been proven negligent and will have to compensate

2 - 50%-94% Probable
- There is evidence of negligence, but the Health Board may be able to prove some contributory negligence on the part of the Claimant or extenuating circumstance

3 - 06%-49% Possible
- The Health Board has a good defence and may be able to defend the claim

4 - 0%-06% Remote
- The Health Board has not been found to be negligent and the Claimant has no case

5 – 0%-06% Remote
- The Health Board has not been found to be negligent and the Claimant has no case

6 - TETA – (Too Early To Assess) – a new claim that is too early to assess

On receipt of quantum reports the Concerns/Claims Managers shall confirm the current status of the claim to ensure that it is active. Consideration should be given to the closure of a file if it has been inactive for a period of 18 months.

7. WELSH RISK POOL (WRP) REQUIREMENTS

The WRP requires notification of any claim that is estimated to cost more than the Health Board's excess (£25,000). On receipt of the quantum reports from the Health Board and solicitors, on a quarterly basis, the WRP will be updated as to any revaluation or new claims handled by external or in-house solicitor other than the Legal and Risk Services that may result in a claim against the WRP.

The Concerns/Claims Managers have a duty to:

- Notify the WRP of all claims that are settled
- Claim reimbursement from the WRP within 4 months of the final payment on the file being made with the minimum of delay

All claims on the WRP should be made on the appropriate forms. On receipt of the form, the WRP may request additional information. It should also be noted that the claim file might be requested by the WRP for audit purposes.

Claims against the WRP can only be made after the claim has been concluded and the full costs have been paid. However, following an interim payment in excess of £100,000, an immediate claim can be made against the WRP.

The Concerns/Claims Managers and Finance Analyst will work together to ensure that the Health Board complies with the calendar and financial requirements of the WRP, thereby aiming to ensure the efficacy of the Health Board to validate dates, payments made, and reimbursement requests as accurate, appropriate and within the required time parameters.

Welsh Risk Pool Assessments

The WRP periodically undertakes detailed reviews of a sample of claims received by the WRP Advisory Board for reimbursement. The purpose of these reviews is to consider the way in which the claim has been managed with emphasis placed upon the lessons learned and the local procedures that are now in place. The WRP will share the lessons learnt via the networks within the NHS organisations in Wales.

The Concerns/Claims Managers will ensure that upon any request from the WRP for a detailed file review, that access is available, but not limited to, the following:

- Claims File
- Clinical Records
- Policies and Procedures
- Site visit if required
- Directorate staff
- Any or all parties involved in the Claim
- Audit Reports
- Health Board Report etc.

The Concerns/Claims Managers will ensure that all parties are involved in the Claim. All clinical Boards are notified of the Assessment, date, time and venue, and are available for interview if so required. You must ensure that any documentation or any changes instigated since the claim are available for the Assessors review.

Upon conclusion of the Assessment, the WRP Assessor will provide a draft report for comment; the Concerns/Claims Managers will review the said report, consult with Directorate staff and will provide the WRP Assessor with any comments or further information as required, prior to the finalisation of the WRP report.

7.1 Financial Limits and the requirement of an LFERform

a) Claims not exceeding £1,000 and discontinued claims

There is no obligation to complete an LFER form in relation to claims where quantum **(damages, claimant's and defendant's costs combined)** does not exceed £1,000

or on claims that have been discontinued. The completion of a LFERin relation to these claims is at the Concerns/Claims Managers' discretion.

b) Claims exceeding £1,000 but not exceeding £25,000

LFERs are to be undertaken on all concluded claims where quantum has exceeded £1,000.00.

c) Claims exceeding £25,000

Detailed LFER's are required whenever quantum on a case exceeds £25,000 on acceptance of liability. These are to be submitted to WRP no later than 60 working days after acceptance of liability.

The Finance Analyst must be informed of the commencement of the LFER.

7.2 Procedure for the reimbursement of claims exceeding £25,000

The following documentation should be completed by the Concerns/Claims Managers Litigation, in conjunction with the Finance Analyst, special losses and submitted to the Welsh Risk Pool (WRP) for claim reimbursements:

- WRP1 claim form
- CMR
- U2
- Schedule of Costs

a) **WRP 1** claim –

This form should be

- An original form
- Signed by an authorised signatory
- Completed in typeface as handwritten forms will not be accepted
- All areas of the claim form should be completed including
- The Claimant's full name including fore name and surname to enable a full search for previous payments
- The name of the lead clinician involved in the claim
- Identify correctly the health body who is the Defendant to the claim especially where the claim relates to a former health authority

b) LFER/Category 7 Checklist

In accordance with WHC (97) 17, Health Boards and Local Health Boards are required to complete a LFERdetailing the nature of the incident, its context, the manner in which it was handled as a claim and changes that have been made to reduce future risk. This is the LFER. The key areas of the LFER that are reviewed include the remedial action taken to prevent future occurrences and areas where

lessons may be learnt. The nature of the alleged negligence should therefore be suitably detailed, as should the breaches of duty of care, to enable the sufficiency of the remedial action to be assessed.

The LFER should satisfy the following conditions:

- It must be typed, as handwritten LFER will not be accepted
- It must be signed by authorised signatories, one of whom must always be the Chief Executive

c) Schedule of Costs

A detailed schedule of the costs incurred by the Health Board or health body (i.e. pre Health Board claims), should be attached to the completed WRP 1 claim form.

The schedule should include the following:

- The date that the payment was made
- To whom the payment was payable
- The description of the payment i.e. what it was for
- Where a former health authority has previously managed the claim, the health body that incurred the costs should be specified.

It is also recommended that schedules should have a cumulative running total of expenditure. To ensure compliance of the WRP reimbursement procedures, the Health Board will be required to make a declaration that all items are net of recoverable VAT on each schedule presented.

7.3 Authorised Signatories

Claims for reimbursement can only be considered for approval if authorised signatories have signed the WRP 1 claim form, LFER and CMRThe WRP stipulate that member organisations must supply the WRP manager with sample signatures of at least 3 officers with delegated responsibility for authorising such claims in accordance with the organisation's standing financial instructions. It is the responsibility of all member organisations to update authorised signatories in the event of personnel changes and to ensure that the schedules supplied to the WRP are in accordance with their own standing financial instructions and schemes of delegation. The Chief Executive must always be one of the signatories on the LFER. Where a health body is aware that its Chief Executive is not going to be available for any reason in the long term, and appoints an Acting Chief Executive, the Acting Chief Executive can complete the signatories forms indicating that he/she is acting up and thereafter may sign the LFER as Acting Chief Executive.

7.5 Reimbursable Costs – Health Board excess is at £25,000.00

Costs associated with losses will be reimbursed by the WRP subject to compliance with the WRP reimbursement procedures.

Any VAT incurred on costs that can be reclaimed by the Health Board, interest earned from payments into Court or any costs recovered from a claimant, should be deducted from the amount claimed for reimbursement.

Where the WRP has reimbursed the Health Board, any monies returned to the Health Board by either the Courts or the Compensation Recovery unit must be paid back to the WRP within 14 days of its receipt.

7.6 Timing of Reimbursement Claims

Requests for reimbursement must be presented to the WRP Advisory Board, notification of the meeting dates are provided periodically by the WRP. It is preferable that reimbursement claims are submitted 10 days before the due WRP Advisory Board meeting date. Any claims received later than the cut off date will be submitted to the next Advisory Board meeting.

Again, the Concerns/Claims Managers Litigation will contact the WRP by e-mail, within 7 days of forwarding, to confirm their receipt of the said request. WRP acknowledgements to be retained on file accordingly.

7.7 Interim Claims

The Health Board is obliged to submit an interim claim for reimbursement for any claim on which the cumulative balance of all payments, disbursements, costs etc associated with the claim, total £100,000.

The interim claim must be submitted within 56 days of this figure being reached, even where this precedes the resolution of costs. The excess for interim claims for all NHS Health Boards is £50,000.

In the event that a claim is received by the WRP, after 56 days of the expenditure totalling £100,000.00, a penalty will be imposed.

When the unclaimed balance (including the interim excess) again reaches £100,000, a further interim claim should be made. This should continue until the claim is finally concluded.

The excess reverts to the standard £25,000 upon conclusion of any claim.

The Health Board must submit a final claim for reimbursement within 4 months of the case being resolved and the costs being paid in full. Any claims for reimbursement submitted outside of this timescale will be penalised in accordance with WRP provisions.

Claims subject to an outstanding appeal to the Compensation Recovery Unit (CRU) should be considered as a final claim, rather than await determination of the CRU appeal. Following a successful CRU appeal any monies received should be remitted back to the WRP as a Post Closure item.
This is to be monitored by both the Finance Analyst and Concerns/Claims Managers to ensure compliance.

Once again, the Concerns/Claims Managers is to contact the WRP by e-mail, within 7 days of forwarding, to confirm their receipt of the said request. WRP acknowledgements will be retained on file accordingly.

7.9 Penalties
Where a claim for reimbursement is submitted outside of the timescale, will not be paid and the if the delay has been with the Clinical Board thy will be liable for the full cost of the settlement

7.10 Concluded claims: accepted date of closure
The above 'trigger point' practice is also adopted when claims reach their conclusion. The date considered as the final 'done date' is the date of the last cheque request for payment of costs etc., (irrespective of whether they are claimant or defence costs).

The date of settlement is the date the Health Board agreed the terms of the settlement and a cheque request for the amount agreed is prepared and duly authorised. The settlement date is not to be considered as the date when cheques are received from the finance department.

7.11 LFER process
The Concerns/ Claims managers will complete the appendix form within 60 working days of making an admission of liability. The Clinical Board will be given time to complete the lesson learned and provide the supporting evidence. The form will then be checked, finance information provided and shared with the Welsh Risk Pool.

7.12 Request for further information and resubmission of rejected claims If insufficient information is provided in the LFER form, the Advisory Board will request further information. This can delay reimbursement to the Health Board and the Board could reject the claim.

7.13 Post closure payments and receipts
The Health Board may receive late invoices in respect of expert fees and other costs after a claims file has been closed and a final reimbursement has been made by the WRP.

For payments made, the WRP will reimburse the additional amount, provided it is satisfied that all reasonable steps were taken by the Health Board to complete all financial transactions prior to submitting a final claim.

The Health Board will need to make a claim using the following documentation:

- WRP 1 claim form
- Updated Schedule of Costs
- Photocopy of the original LFER

7.14 Notifying the WRP of other claims
In accordance with WHC (2000) 12, the Concerns/Claims Managers is obliged to notify the WRP Manager of the following:

a) WRP 2 Forms
Any existing claim which is likely to become subject to a claim for reimbursement. The WRP acknowledges that it now has available to it, financial information relating to the value of claims from Legal and Risk Services, therefore, this requirement now only relates to claims, which are handled by either external or in-house solicitors, i.e. those other than Legal and Risk Services. In all such claims, which are likely to exceed excess, the Health Board must lodge a WRP 2 form with the WRP. Failure to notify the WRP of the existence of such a claim, may result in the WRP Advisory Board rejecting the claim.

b) WRP 3 Forms
All claims settled below excess should be notified to the WRP on WRP 3 Forms.

c) WRP4 Forms
WRP 4 forms must be completed and submitted to the WRP by the Legal Services Manager on all claims in excess of £1,000.00 to £30,000.00. The Legal Services Manager sends a hard copy of the signed WRP 4 form to the Finance Analyst.

8. CONCLUSION OF THE CLAIM

8.1 Closed files
There are several ways in which a claim may be closed:

- Discontinued
- Formally withdrawn
- Statute barred
- Settlement
- Nothing further heard

Where settlement has been made, the closure of a claim will include settlement of the claimant's costs. It will also include payment of the Health Board's defence costs

and any other outstanding fees. The database should be updated to show the date of closure and the outcome of the claim.

8.1 Closure of files

The Finance Analyst must be advised of the closure of all claims with a monetary value. An Annex form is e-mailed to the Finance Analyst, to enable this information to be recording onto LASPAR. The Finance Analyst also receives a copy of the WRP 4 form.

8.2 Notification to the relevant parties to the claim

At the conclusion of a claim, the Concerns/Claims Managers shall advise the others involved in the Claim, of the outcome of the claim; that the claim is to be closed and thank them for their kind assistance.

8.3 Reviewing files at conclusion

a) Lessons learnt

When the Concerns/Claims Managers identifies or is notified that a claim has been closed, a decision will be made upon whether the preparation of a further LFER is appropriate. This decision is based upon Welsh Risk Pool requirements as set out above or, if LFER is not required in accordance with WRP requirements, whether it is felt that the matter has progressed to a stage that a LFER is justified.

The Concerns/Claims Managers will review all closed files. Once the LFER has been completed or a decision has been made to close the file without a further, the following actions will be undertaken:

a) The Concerns/Claims Managers will review the file and decide whether to prepare an action plan, identifying the failures, lessons learnt, action to be taken, evidence and audit.

b) If an action plan is appropriate, the Concerns/Claims Managers will then speak to the Clinical Board or other relevant member of staff with conduct of the claim to review the action plan in relation to the failures identified, lessons learnt, action to be taken, evidence and audit.

c) The member of staff with conduct of the claim will then provide the Legal Services Manager with the name of the individual who is responsible for the action and due date.

d) The Concerns/Claims Managers will then finalise the action plan and send a copy to the individual with responsibility for the action, noting the due date.

e) The Lead Officers Group shall consider the action plan and further recommendations may be made. If this is the case, the Legal Services Manager

f) Shall discuss these with the member of staff with responsibility for the claim, as set out above.

g) The Concerns/Claims Managers will enter the action plan into a bring forward system with a view to monitoring compliance with the due date and collating evidence in relation to each action.

h) Once each action has been addressed and evidence in relation to each action has been collated, the Concerns/Claims Managers will then provide the member of staff with conduct of the complaint with a completed action plan for display/circulation to all staff within the Directorate.

- Facilitating and promoting change within the organisation through the development of the lessons learnt process
- Receiving progress reports on current and recently closed litigation reports
- Receiving annual litigation reports

At every meeting the group will consider in detail the failures identified, lessons learnt, actions to be taken and relevant audits in relation to all relevant claims that have been concluded within the period since the Group last met.

In relation to each claim the Group shall consider the following documents:

- Case Synopsis
- Action Plan
- Concluded action plan together with any relevant documentation in relation to actions taken
- Concluded audits

Having considered the case synopsis and action plan, the group shall:

- Decide whether the failures identified, lessons learnt and actions to be taken are satisfactory
- Decide whether any additional failures, lessons learnt and actions can be identified and make recommendations for amendments to the action plan
- Consider whether the claim should be referred to the Clinical Audit Department for consideration and if so, identify the nature of the audit to be undertaken

It will be noted on all claims files whether a claim has been referred to the Lead Officers Group and if so, the outcome of that referral.

9.2 Compensation Recovery Unit

The rules concerning the repayment of benefits to the Compensation Recovery Unit (CRU) have recently changed under the provisions of the Social Security (Recovery of Benefits) Act l997.

The main points from the Act are as follows: -

- The new rules apply to all claims settled on or after the 6th October l997, including claims arising out of accidents prior to 1st January 1989 which were not covered by original Compensation Recovery Scheme
- The current small payment exemption for compensation of £2,500 or less will no longer apply from the 6th October l997, and the CRU must be informed of all claims and a Certificate of Total Benefit obtained before settlement.
- The Health Board repays the full amount of recoverable benefits to the CRU
- No benefits may be taken from the claimant's general damages i.e. those damages paid for compensation for pain and suffering, loss of amenity, loss of congenial employment
- The Health Board will only be able to reduce the compensation payable to a claimant where DSS benefits have been paid for the same reason that compensation has been awarded e.g. Statutory Sick Pay and Sickness Benefit may be deducted from the compensation award for loss of earnings resulting - from the relevant accident

The new legislation will remove the possibility of a small nuisance settlement in cases where a large amount of benefits has accrued. Further, should the benefits to be repaid to the CRU exceed the special damages claim, the Health Board will have to repay the full amount of benefit to the CRU as well as general damages awarded to the claimant, which will remain ring fenced. This will increase the Health Board's outlay from the present position whereby any benefits to be recovered in excess of special damages would be recouped from general damages. The Director Governance & Communications' role in this process is limited. Any documentation received will need to be sent to the Health Board's legal advisor for action.

9.4 Criminal Injuries Compensation Authority

The Board entertains applications for payments of compensation where the applicant has sustained personal injury attributable to a crime of violence. As with personal injury claims these will only be considered if made within three years of the incident, giving rise to injury. Minor injuries are excluded (i.e. where awards would be less than £1,000 after the deduction of benefits received). A person can simultaneously pursue the Health Board and the Compensation Board, but the individual will not recover a payment in duplicate.

Appendix A

Complaints Standards Authority – Wales
Concerns and Complaints Policy for Public Services Providers in Wales

This model policy is designed for public services providers in Wales. It represents a minimum standard of complaint handling for public bodies in Wales.

The Policy is fully compatible with the Welsh Language Standards Regulations of 2018.

Please note that NHS bodies in Wales adhere to the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, known as 'Putting Things Right'.

When the content of this policy conflicts with the Putting Things Right regulations, the Putting Things Right regulations will take precedence, including when references are made to timescales.

Also, the Social Services Complaints Procedure (Wales) Regulations 2014 outline the procedure for handling complaints about Social Services issues in Wales.

A Model Concerns and Complaints Policy Cardiff and Vale UHB has reviewed our process in line with the Model Concerns Policy

Cardiff and Vale UHB is committed to dealing effectively with any concerns or complaints you may have about our services. We aim to clarify any issues you may be unsure about. If possible, we'll put right any mistakes we may have made. We will provide any service you're entitled to which we have failed to deliver. If we did something wrong, we'll apologise and, where possible, try to put things right for you. We aim to learn from our mistakes and use the information we gain from complaints to improve our services.

When to use this policy

When you express your concerns or complain to us, we will usually respond in the way we explain below. However, sometimes you may have a statutory right of appeal so, rather than investigate your concern, we will explain to you how you can appeal. Sometimes, you might be concerned about matters that are not covered by this policy *[e.g. concerns relating to other organisations, matters which are not related to direct or indirect Patient Care, employee relation matters, issues which are best managed via the police]* and we will then advise you about how to make your concerns known.

This policy does not apply to 'Freedom of Information' or data access issues. Please contact *[insert relevant contact details]*.

Complaints Team staff can advise on the type and scope of complaints they can consider.

Asking us to provide a service?

If you are approaching us to request a service, this policy doesn't apply. If you make a request for a service and then are not happy with our response, you will be able to make your concern known as we describe below.

Informal resolution

If you are unhappy with the treatment or care you are receiving, we would encourage you to raise your concerns as soon as possible, preferably to senior staff on duty at the time of the incident or the appropriate ward, hospital or community manager. Alternatively, please contact a member of the Concerns Department and they will be happy to discuss your concerns with you and pass them on to the relevant department.

How to express concern or complain formally

You can express your concern in any of the following ways:

The Concerns Office is open between the hours of 9 am to 5 pm (7 days per week) Please call on the following telephone numbers in office hours if you wish to speak with a member of the Concerns Team.

- **029 218 36318**
- **029 218 36319**
- **029 218 36323**
- **029 218 36340**

For BSL users the phone line is accessible via sign live https://youtu.be/Ygxdvhl9X4E please see the video explaining the service.

You can also fill in our **Concerns Form**, e mail the team at concerns@wales.nhs.uk or write to us at Chief Executive, Cardiff and Vale University Health Board, Maes y Coed Road, Llanishen, Cardiff CF14 4HH.

Other than in exceptional circumstances, a complaint should be made as quickly as possible in relation to the problem arising. If there is a good reason why the complaint cannot be made sooner, it may still be possible to investigate your concerns, as long as no more than a year has passed. We may exceptionally be able to look at concerns which are brought to our attention later than a year. However, you will have to explain why you have not been able to bring it to our attention earlier and we will need to have sufficient information about the issue to allow us to consider it properly. In any event, we will not consider any concerns about matters that took place more than three years ago.

Concerns Form - Manylion am y pryder.doc (*Word, 130Kb*)
Once the complaint form has been completed you can either send it by email to: concerns@wales.nhs.uk (you will receive an e mail acknowledgement within two working days), or by post to:

Chief Executive
Cardiff and Vale University Health Board Headquarters

Woodland House
Maes y Coed Road
Cardiff
CF14 4HH

You may submit a complaint on behalf of someone else. However, the Health Board will have to ask for permission/consent from the person involved (if they are aged over 18 and have capacity) to investigate the issues raised.

We would encourage you to contact the Complaints Department in the first instance to try and achieve a timely and informal resolution to your concerns. If you are not happy with any informal course of action, then you will still be able to submit a formal complaint.

You will receive an acknowledgement letter within two working days of receipt of your formal complaint. This letter will provide you with contact details of the Complaints Co-ordinator who is processing your complaint. If you have any questions, please feel free to contact this person.

The aim is for you to receive a written response to your complaint within 30 **working** days. However, if a more in-depth investigation is required, the Health Board can take up to 6 months to complete its investigation.

In exceptional circumstances an investigation may take longer than 6 months. On occasions, we may ask you if you wish to meet with members of the clinical team who will discuss your complaint with you. This can be prior to, during or following the investigation.

We place great importance on any feedback we receive and the way in which we manage and investigate concerns you may have. By understanding why our patients have cause to complain, we can improve the quality of care and treatment provided to anyone using our services.

If you would like to provide feedback following raising a concern with us please complete the form below and send in an email to the above address.

Concerns Feedback Form.doc (*Word, 98Kb*)

We aim to have concern and complaint forms available at all of our service outlets and public areas and also at appropriate locations they are available with leaflets in all of our Information Centres in the main entrance of the hospitals and at our main reception desks.

What if there is more than one body involved?

If your complaint covers more than one body (another Health or social care provider) with your consent *we* will usually work with them to decide who should take the lead in dealing with your concerns. You will then be given the name of the person responsible for communicating with you while we consider your complaint.

If the complaint is about a body working on our behalf you may wish to raise the matter informally with them first. However, if you want to express your concern or complaint formally, we will look into this ourselves and respond to you.

Investigation

We will tell you who we have asked to look into your concern or complaint. If your concern is straightforward, we'll usually ask somebody from the relevant service area to look into it and respond to you. If it is more serious, we may also use someone from elsewhere. We will set out our understanding of your concerns and ask you to confirm that we are right. We'll also ask you to tell us what outcome you're hoping for.

The person looking at your complaint will usually need to see the files we hold relevant to your complaint. If you don't want this to happen, it's important that you tell us.

If there is a simple solution to your problem, we may ask you if you're happy to accept this. For example, where you asked for a service and we see straight away that you should have had it, we will offer to provide the service rather than investigate and produce a report. We will aim to resolve concerns as quickly as possible and expect to deal with the vast majority within 30 working days *[if appropriate, bodies may wish to insert a shorter timescale here]*. If your complaint is more complex, we will:

• Let you know within this time why we think it may take longer to investigate.

• Tell you how long we expect it to take.

• Let you know where we have reached with the investigation, and

• Give you regular updates, including telling you whether any developments might change our original estimate.

The person who is investigating your concerns will firstly aim to establish the facts. The extent of the investigation will depend upon how complex and how serious the issues you have raised are. In complex cases, we will draw up an investigation plan.

In some instances, we may ask to meet with you to discuss your concerns. Occasionally, we might suggest mediation or another method to try to resolve disputes.

We'll look at relevant evidence. This could include information you have provided, our case files, notes of conversations, letters, emails or whatever may be relevant to your particular concern. If necessary, we'll talk to the staff or others involved and look at our policies, any legal entitlement and guidance.

Outcome

If we formally investigate your complaint, we will let you know what we find. If necessary, we will produce a report. We'll explain how and why we came to our conclusions.

If we find that we made a mistake, we'll tell you what happened and why.

If we find there is a fault in our systems or the way we do things, we'll tell you what it is and how we plan to change things to stop it happening again.

If we make a mistake, we will always apologise for it.

Putting Things Right

If we didn't provide you with a service you should have had, we'll aim to provide it now, if that's possible. If we didn't do something well, we'll aim to put it right. If you have lost out as a result of a mistake on our part, we'll try to put you back in the position you would have been in if we'd done things properly.

If you had to pay for a service yourself, when we should have reasonably provided it for you, we will try to refund the cost.

The Ombudsman

If we do not succeed in resolving your complaint, you may complain to the Public Services Ombudsman for Wales. The Ombudsman is independent of all government bodies and can look into your complaint if you believe that you personally, or the person on whose behalf you are complaining:

• Have been treated unfairly or received a bad service through some failure on the part of the service provider.

• Have been disadvantaged personally by a service failure or have been treated unfairly.

The Ombudsman normally expects you to bring your concerns to our attention first and to give us a chance to put things right. You can contact the Ombudsman by:

• Phone: 0300 790 0203

• Email: ask@ombudsman.wales

• The website: www.ombudsman.wales

• Writing to: Public Services Ombudsman for Wales

1 Ffordd yr Hen Gae, Pencoed CF35 5LJ

There are also other organisations that consider complaints. For example, the Welsh Language Commissioner's Office deals with complaints about services in Welsh. We can advise you about such organisations.

Learning lessons

We take your concerns and complaints seriously and try to learn from any mistakes we've made. Our senior management team considers a summary of all complaints quarterly and is made aware of all serious complaints. Our Learning committee also considers our response to complaints at least twice a year. We share summary (anonymised) information on complaints received and complaints outcomes with the Ombudsman as part of our commitment to accountability and learning from complaints.

Where there is a need for significant change, we will develop an action plan setting out what we will do, who will do it and when we plan to do it. We will let you know when changes we've promised have been made.

What if you need help?

Our staff will aim to help you make your concerns known to us. If you need extra assistance, we will try to put you in touch with someone who can help. You may wish to contact *[insert examples appropriate to the service provider here e.g. advocacy services, Age Cymru, Shelter etc.]* who may be able to assist you.

Advocacy

Community Health Council

Community Health Councils (CHCs) were set up originally by Act of Parliament in 1974 as **independent "Watchdogs"** to monitor and review services provided by the NHS.

The South Glamorgan members are recruited from the general public and appointments are made by the Welsh Assembly Government, the Local Authorities and also from established voluntary organisations. The members are unpaid and receive out-of-pocket expenses only and are supported by paid support staff.

The CHC provide a free independent advocacy service should you wish to raise a concern in any part of the NHS. They can:

- advise you on available health services
- help you to find further information
- help you to deal with other health bodies
- Listen to your comments. If you feel that you need to complain about any aspect of the Health Service, we can help you by:
    - providing information about NHS Complaints Procedures
    - making enquiries on your behalf
    - Acting as a Patient's Friend at meetings with Health Service Managers.

Contact Details

South Glamorgan CHC,
Pro-Copy Business Centre (Rear)
Parc Tŷ Glas
Llanishen
Cardiff
CF14 5DU

Telephone: 02920 750112

Email: SouthGlam.Chiefofficer@waleschc.org.uk

Advocacy Support Cymru (ASC)

ASC is a specialist advocacy provider currently delivering independent advocacy services in parts of South and Mid Wales.

ASC believe independent advocacy is important because it seeks to give a voice to people who can't make themselves heard. Advocacy helps to ensure that people are

as involved as they can be in the things that affect them, and are able to communicate their needs and wishes to others who may have influence or power over their lives.

Contact Details
ASC
Charterhouse 1
Links Business Park
Fortran Road
St Mellons
Cardiff CF3 0LT

Telephone: 02920 540444
Fax: 029 2073 5620

E Mail: info@ascymru.org.uk

Advocacy Support Cymru is the new service provider for the Independent Mental Capacity (IMCA)

You can also use this concerns and complaints policy if you are under the age of 18. If you need help, you can speak to someone on the Meic Helpline:

• Phone 0808 802 3456

• Website www.meiccymru.org

or contact the Children's Commissioner for Wales. Contact details are:

• Phone 0808 801 1000

• Email post@childcomwales.org.uk

• Website www.childcom.org.uk

What we expect from you

In times of trouble or distress, some people may act out of character. There may have been upsetting or distressing circumstances leading up to a concern or a complaint. We do not view behaviour as unacceptable just because someone is forceful or determined.

We believe that all complainants have the right to be heard, understood and respected. However, we also consider that our staff have the same rights. We therefore expect you to be polite and courteous in your dealings with us. We will not tolerate aggressive or abusive behaviour, unreasonable demands or unreasonable persistence. We have a separate policy to manage situations when we find that someone's actions are unacceptable.

Appendix 1

Cardiff and Vale University Health Board Concerns form

Section A: Your Details

Title:

Name:

DOB:

Address:

Contact Details

Telephone:
Mobile:
Email:

Are you the Patient?

Y / N

Section B: a concern on behalf of someone else

Title:

Name:

DOB:

Address:

Section C: Details about the concern

If you are raising this concern on behalf of someone else, what is your relationship to the patient?:

Date event/incident occurred:

Have you already put your concern to the frontline staff responsible for delivering the service? If so, please give brief details of how and when you did so:

Summary of your concerns/key issues

In your opinion, what went wrong?

Specific questions you would like answered:

Details of what you would like to happen as a result of your complaint.

To be completed where the person raising the concern is not the patient.

I hereby authorise

Name of person raising the concern:	
Address:	

To act on my behalf and to receive any and all information that may be relevant to the concern.

I hereby agree that the health records and any personal information can be used in the investigation of the concern. I understand that access to records and personal information will be limited only to those who need to see them in order to investigate the issues raised and, only those sections of the health records relevant to the investigation will be used.

Signature of patient:	
Date:	

Please return to:

Concerns Department
Woodland House
Maes-y-Coed Road
Cardiff
CF14 4HH concerns@wales.nhs.uk