Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Proposed NHS Redress (Wales) Measure Committee

Proposed NHS Redress (Wales) Measure 2007

Stage 1 Committee Report
January 2008

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PROPOSED NHS REDRESS (WALES) MEASURE COMMITTEE

COMMITTEE MEMBERSHIP

Member	**Political Party**
Jonathan Morgan	Welsh Conservative Party
Edwina Hart	Labour
Helen Mary Jones	Plaid Cymru
Val Lloyd	Labour
Jenny Randerson	Liberal Democrats

SUMMARY OF RECOMMENDATIONS

Committee approach

1. Much of the evidence we received commented on some detailed issues relating to redress which are more relevant to the drafting of the regulations under the Measure and we would urge the Minister to take account of these when preparing regulations for consultation (paragraph 10).

Lack of information

2. There are still some areas where we are concerned about the lack of information we have had to support our consideration of the general principles and we identify these elsewhere in the report. We would expect the Minister to cover these specific areas in the Stage 1 debate so that all Assembly Members can reach an informed view on the general principles before the Measure is subject to more detailed scrutiny (paragraph 19).

Framework nature of Measure

3. We recognise that as the first Assembly Measure to have been scrutinised by a committee at Stage 1, the proposed NHS Redress Measure has attracted some criticism because of its framework nature. It is not unusual for legislation to confer regulation making powers on Ministers. However, we recommend that where future Measures take a similar approach in conferring wide regulation making powers to Welsh Ministers, they should be accompanied by a more detailed report on the policy behind the legislation to allow considered scrutiny by the Assembly. Furthermore, the policy should always have been developed before any proposed Measure is introduced into the Assembly (paragraph 31).

Relationship of the redress arrangements with the complaints procedure

4. We recommend that the Minister ensures there is complete clarity in the regulations as to how the complaints procedure and the Speedy Resolution Scheme will work alongside any redress arrangements (paragraph 42).

5. We recommend there should also be sufficient safeguards built into the redress arrangements to ensure that patients who do not receive a financial award do not feel that their complaint was any less valid than a patient who did (paragraph 43).

No fault schemes

6. Given the evidence we have received in relation to no-fault based schemes we conclude that this should not be explored at present. A great deal of further work and investigation would need to be carried out before

decisions were made on anything other than a tort based scheme of redress (paragraph 52).

Scope of the redress scheme (Sections 1 & 2)

Inclusion of primary care under the redress scheme

7. We recommend that before any decision is taken to expand the redress arrangements to include primary care a full evaluation is conducted of the scheme's operation in the secondary care setting. We also recommend that the Minister should carry out a full and thorough consultation with stakeholders on any proposed expansion of the scheme to include primary healthcare and that this should take place prior to the drafting of the relevant regulations (paragraph 71).

Impact on health professionals

8. We recommend the Minister considers this area carefully and ensures that sufficient safeguards are built into the arrangements to ensure that NHS staff have confidence in the systems and are protected from unintended consequences (paragraph 81).

Compensation limits

9. We consider that it is appropriate for the limits for compensation to be set in regulations rather than in the Measure to ensure there is flexibility in the scheme (paragraph 88).

10. We recommend the Minister considers in further detail the level of the upper limit for compensation and, in particular, the view put forward regarding the danger of setting too low a limit which could mean that some cases may fall outside the redress scheme, but may not be eligible for public funding to take forward a case through the courts. The upper limit for compensation will impact on the type and number of cases which are eligible for redress arrangements and this is an area where we would expect the Minister to provide further information for the Stage 1 debate (paragraph 89).

Investigations under the scheme (Sections 4 & 5)

11. The investigations process is key to the success of any redress arrangements and we urge the Minister to ensure that the detailed evidence we have received on the investigations process is taken into account by the working group and during the formulation of the relevant regulations (paragraph 113).

12. We consider that interim time limits are required to ensure that both patients and NHS staff have confidence in any redress arrangements. We consider that it is appropriate for these time limits to be set out in future regulations under the Measure. We recommend, however, that the

Measure should be amended to require that regulations must make provision for time limits in relation to the investigations process (paragraph 114).

Withholding of investigation reports

13. We recommend that the Measure should be strengthened to prescribe that investigation reports will normally be disclosed and that they may only be withheld in exceptional circumstances. Safeguards should also be included in the Measure to ensure that any decision to withhold an investigation report should be reviewed by a body which is independent of the NHS organisation that is concerned in the case (paragraph 124).

Duty to conduct inquiries

14. We remain concerned about the lack of detail about how the provisions will operate and call for the Minister to make it clear in the regulations where the duty to conduct inquiries falls and how it will be enforced and monitored. We would expect the Minister to provide further information on this for the Stage 1 debate (paragraph 131).

Advice and assistance under the scheme (Sections 7 & 8)

15. We recognise the importance of providing clear, consistent advice and information to patients under the redress arrangements and we welcome the commitment to provide advice and assistance free of charge as part of the redress scheme (paragraph 153).

16. We note the interim findings of the working groups on this issue and call for the Minister to provide further details on the operation of these provisions for the Stage 1 debate. In particular, we seek clarification from the Minister on when advice and assistance will be accessible under the scheme, who will provide such advice and assistance and how these services will be monitored to ensure consistency of approach (paragraph 154).

Structure of the scheme (Section 9)

17. We recommend that the regulations make provision for consistent management and guidance of the redress arrangements (paragraph 162).

Powers to make regulations (Section 11)

18. We welcome the Minister's commitment to bring forward amendments at Stage 2 to tighten up the procedures for regulations made under the Measure and support the specific proposals outlined by the Subordinate Legislation Committee for a greater number of regulations to be subject to the affirmative procedure (paragraph 173).

Duty to consult on regulations

19. We recognise the Minister's commitment to consultation and the recommendations made by the Subordinate Legislation Committee. However, the evidence we received strongly supports the need for a statutory duty to consult on regulations and we recommend that given the wide regulation making powers this Measure confers on Welsh Ministers there should be a statutory duty to consult on all regulations subject to the affirmative procedure (paragraph 178).

Financial and resource considerations under the scheme

20. We note the Finance Committee's recommendation that the Stage 1 debate should not take place before a more detailed assessment of the financial impact of the scheme has been provided by the Minister. We acknowledge the Finance Committee's concerns and recognise that it is important that any information which is laid in the Assembly accompanying a legislative proposal should be accurate and specific to Wales. We have received an assurance from the Minister that the necessary financial information will be provided for the Stage 1 debate (paragraph 191).

Conclusion

21. The Committee welcomes this first proposed Assembly Measure and agrees unanimously to its general principles subject to the additional information set out in this report being presented by the Minister for the Stage 1 debate.

22. We recognise that the process taken for this first proposed Measure is not necessarily one that will set a precedent for future Measures. The proposed Measure is a product of the NHS Redress Act 2006 and, as such, much of the policy was still being developed while we were conducting our scrutiny work. This made it more difficult for stakeholders to come to a view on some of the general principles.

23. We are grateful to the Minister for the information provided by the Working Groups which has helped our consideration. We consider, however, that a substantial amount of detail still needs to be finalised before the regulations under the proposed Measure can be prepared.

24. We expect future Measures to be handled differently. We consider that the policy behind a legislative proposal must be finalised before a proposed Measure is introduced for consideration by the Assembly. This will allow a greater degree of engagement with external stakeholders in terms of whether the legislation meets the policy objectives. It will also allow the relevant legislative committee to undertake proper and detailed scrutiny of the proposals (paragraphs 192-195).

1. INTRODUCTION

1. The Minister for Health and Social Services introduced the Proposed NHS Redress (Wales) Measure 2007 on 2 July 2007 and made a statement in plenary the following day.[1] The Proposed NHS Redress (Wales) Measure Committee was established by a resolution of the Assembly on 4 July.

2. The role of the committee is to, "consider and report on the general principles of the proposed Measure" (SO 23.23); to conduct scrutiny under Stage 1 of the Assembly's legislation process.

Reporting on the general principles

3. This is the first Committee of the Assembly to report on the general principles of a proposed Assembly Measure and we considered carefully our approach to this work. The Assembly's Standing Orders provide, in Stage 1 consideration, for a degree of scrutiny in committee that does not exist in the scrutiny of Bills in Westminster.

4. We have therefore sought to establish whether the general principles of the particular piece of legislation before us are sound and have taken consideration of the general principles to mean more than a cursory discussion about whether or not a decision to legislate in a broad area of public policy is a valid one. In its report, *The Legislative Process*,[2] the House of Commons Modernisation Committee considered the purpose of pre-legislative scrutiny to be "to make better laws by improving the scrutiny of bills and drawing the wider public more effectively into the Parliamentary process."[3] While our consideration is not pre-legislative scrutiny (given that the legislation has already been introduced) we consider this view applies equally to Stage 1 consideration of a proposed Measure.

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[1] Record of Plenary Proceedings (RoP), 3 July 2007, which can be found at: http://www.assemblywales.org/bus-home/bus-chamber/bus-chamber-third-assembly-rop.htm?act=dis&id=55675&ds=7/2007#rhif3. (NB: unless otherwise stated, subsequent references in this report to RoP refer to the proceedings of the Proposed NHS Redress (Wales) Measure Committee.)

[2] Select Committee on Modernisation of the House of Commons: The Legislative Process, First Report of Session 2005-06 (HC 1097)

[3] Ibid., paragraph 26

2. BACKGROUND

5. The need for more effective and fair redress arrangements was set out in *Making the Connections*[4] in 2004, which set out a vision for public services in Wales and in the *Healthcare Quality Improvement Plan*[5] published by the Assembly Government in November 2006.

6. The powers for the Assembly to legislate in this area derive from section 17 the NHS Redress Act 2006[6] which conferred regulation making powers on the Assembly as constituted under the Government of Wales Act 1998. These powers were subsequently converted to Measure making powers by Order. The Measure aims to provide a system of fair redress for NHS patients in Wales; a speedier and less adversarial process where negligence has been determined and compensation is likely to be of relatively low value. It will give patients access to compensation, without recourse to legal proceedings.

7. Redress arrangements form part of an overall package of reforms proposed by the Minister which includes the NHS complaints procedure. It is anticipated that together these will provide a holistic package of remedies including investigation, apologies, remedial action and in some cases financial compensation for patients who receive treatment or services from the NHS. Work on these reforms is being taken forward by the Putting Things Right project. The key policy drivers for the proposed reforms are outlined in the Explanatory Memorandum to the Measure.[7]

[4] Welsh Assembly Government's Making the Connections policy, can be found at: http://new.wales.gov.uk/about/strategy/makingtheconnections/?lang=en
[5] Welsh Assembly Government's Healthcare Quality Improvement Plan, can be found at: http://new.wales.gov.uk/topics/health/nhswales/healthservice/qualitystandardsandsafety/QuIP/?lang=en
[6] NHS Redress Act 2006, Framework Power for Wales (section 17), can be found at: http://www.opsi.gov.uk/acts/acts2006/ukpga_20060044_en_1#pb2-l1g17
[7] Explanatory Memorandum to the Proposed NHS Redress (Wales) Measure 2007, paragraph 3.4

3. COMMITTEE APPROACH

8. The Committee consulted widely, issuing an open call for written evidence and taking oral evidence from a range of organisations who will be involved in redress arrangements. We received evidence from over 30 organisations and individuals and a list of those who contributed to our work is included at Annex A. We have had to conduct our scrutiny in a relatively short time and are grateful to those who gave evidence at short notice. Their contribution, both to our work and the consideration of the proposed Measure, has been invaluable.

9. The evidence we received inevitably reflected the wide range of interests of the respective groups involved in the area of redress; patients, NHS Trusts and managers, health professionals and their representative organisations, and those involved in providing advice and guidance to patients. In reporting on the proposed Measure we have taken account of the views of each of the distinct groups involved in this area and have sought to reflect the key issues in relation to the content of the Measure, adopting a consensual approach.

10. Much of the evidence we received commented on some detailed issues relating to redress which are more relevant to the drafting of the regulations under the Measure and we would urge the Minister to take account of these when preparing regulations for consultation.

11. The Subordinate Legislation Committee and the Finance Committee have also reported on the proposed Measure and the Chairs of both committees gave oral evidence to help inform our report.[8]

[8] The Finance Committee report, FIN(3)-07-R02: Report on NHS Redress (Wales) Measure 2007, is available at: http://www.assemblywales.org/cr-ld6827-e.pdf; and the Subordinate Legislation Committee report, Report on the NHS Redress (Wales) Measure 2007, is available at: http://www.assemblywales.org/slc_3_-10-07_report_on_nhs_redress_measure_e.pdf. The Committee Chairs gave evidence to the Measure Committee: RoP, paragraphs [2]-[40], 6 November 2007.

4. THE POLICY BACKGROUND

The need for legislation

12. Witnesses outlined the problems with the current system of redress. Action Against Medical Accidents (AvMA) told us that they considered the legal process to be stressful to all involved and that it can sometimes be damaging to health professionals. AvMA stated that:

> "People who have been affected by clinical errors in the NHS sometimes find it very difficult to find out the full facts about what happened; to be assured that steps will be taken to reduce the risk of similar errors affecting other people; and to obtain compensation for injuries or losses that they have suffered as a result of sub-standard care in the NHS."[9]

13. We were also told about the cultural problems within the NHS which lead to an adversarial approach and a poor outcome for patients. The Wales Board of Community Health Councils (CHCs) referred to the difficulties in gaining the evidence for investigations and stated that at the start of an investigation process "NHS services will not want to state liability… and therein lies a major cultural problem."[10]

Lack of information

14. In evidence, we heard that there was widespread support for the need for redress arrangements as proposed in the Measure; that a speedier, less adversarial system is needed for staff and patients, within the secondary care sector. There was opposition to extending the scheme to primary care and the detailed concerns on this are outlined later in this report.

15. Despite general support for redress arrangements a significant number of witnesses expressed difficulty in assessing whether the Measure would achieve the policy objectives and many found they could not make an objective assessment of the implications of the Measure because of the lack of detail. There was also some concern that there were few substantive provisions in the Measure.

16. The National Assembly's Finance Committee reported on the Measure on 22 October 2007 and expressed concern about the lack of information to assess the cost of the Measure and noted that work was still underway.[11] The Committee's judgement was that it could not reliably assess the impact of the proposed NHS Redress Measure and concluded that they had little alternative but to recommend that the Stage 1 debate was not scheduled until Members had an opportunity to consider a more accurate estimate of the costs

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[9] Written evidence, NHSR19
[10] RoP, paragraph [53], 2 October 2007
[11] The Finance Committee report, FIN(3)-07-R02: Report on NHS Redress (Wales) Measure 2007, is available at: http://www.assemblywales.org/cr-ld6827-e.pdf.

involved. They were told by Assembly Government officials that an interim report on the costs would be available by the end of 2007.[12] Further details on the financial impacts of the Measure are set out later in this report.

17. We wrote to the Minister on 4 October 2007[13] outlining our concern that there appeared to be a substantial amount of work still to be completed on the detail of the proposed redress scheme and asked for a detailed account of the work undertaken so far. The Minister's reply[14] provided information about three working groups taking part in the Putting Things Right project, their membership and their terms of reference:

- The Legal Advice Working Group aims to provide an interim report to the Minister by mid January 2008;

- The Investigations and Process Working Group aims to provide an interim report by mid January 2008 and make final recommendations by May 2008; and

- The Advocacy and Assistance Working Group will not start its work until November 2007, allowing it to take account of the work undertaken by the other groups.

18. The Minister told us that she did not expect to bring forward regulations until at least mid-way through 2008 but offered to provide us with the interim reports of the working groups in January 2008 to help facilitate our consideration of the general principles. These reports[15] were received at the end of our consideration of the proposed Measure and while we have reflected the additional information in our report where appropriate, we have not been able to test the detailed proposals with witnesses.

19. We recognise the importance of the working groups' findings informing the regulations that will be brought forward under the Measure and particularly in formulating guidance that will support redress arrangements when they are rolled out. **There are still some areas where we are concerned about the lack of information we have had to support our consideration of the general principles and we identify these elsewhere in the report. We would expect the Minister to cover these specific areas in the Stage 1 debate so that all Assembly Members can reach an informed view on the general principles before the Measure is subject to more detailed scrutiny.**

[12] RoP, Finance Committee, paragraph [80], 20 September 2007
[13] Annex B
[14] Annex C
[15] Annex E

5. GENERAL COMMENTS ON THE MEASURE

Framework nature of Measure

20. The proposed Measure is enabling in nature and has been described as a "skeleton" or "framework" Measure by many witnesses. It allows the detail of any redress scheme to be made through regulations by Welsh Ministers and it has been argued that this limits the opportunity for scrutiny by the Assembly.

21. The powers to legislate in this area derive from the framework powers contained in section 17 of the NHS Redress Act 2006 and following the enactment of the Government of Wales Act 2006 (GOWA 2006) the power lay with Welsh Ministers. The powers were then converted to Measure making powers by virtue of a Conversion Order[16] in 2007. The Order inserted Matter 9.1 into Field 9 of Schedule 5 to the GOWA 2006. The framework nature of the Measure effectively passes most of the powers to make a redress scheme back to Welsh Ministers.

22. Some witnesses were comfortable with Welsh Ministers setting out the details of the scheme in regulations, providing there was full consultation with stakeholders. Many organisations were concerned that as this was the first Assembly Measure it would set a standard and that the framework nature of the Measure curtailed scrutiny and did not allow for engagement with civic society.

23. The Legal Services Commission (LSC) argued for "more detail to be set out in the Measure rather than to be left to regulations".[17] They recognised that whilst some of the detail would need to be left to regulations to ensure flexibility, provisions relating to the structure of the scheme, funding, independence of advice, availability of appeals and time limits should be defined in the Measure.

24. The British Medical Association (BMA) were wary about the scheme being made by regulations "because we see that as being ministerial whim."[18] They went on to say that "any change that might incur a charge to public money should be decided upon by the whole Assembly rather than by Ministers."[19] The Chartered Society of Physiotherapy in Wales were concerned that as this was the first Assembly Measure it would set a standard; "Powers are now passing to Ministers, rather than the Assembly as a whole." They continued: "this Measure will make powers that potentially give Ministers unlimited discretion."[20]

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[16] National Assembly for Wales (Legislative Competence) (Conversion of Framework Powers) Order 2007, can be found at: http://www.opsi.gov.uk/si/si2007/uksi_20070910_en_1
[17] Written evidence, NHSR11
[18] RoP, paragraph [159], 11 October 2007
[19] Ibid., paragraph [161]
[20] Written evidence, NHSR10

25. Where witnesses commented more on the constitutional position, they were broadly against the framework nature of the Measure. Cymru Yfory referred to the concerns expressed by the House of Lords Delegated Powers and Regulatory Reform Committee when the NHS Redress Bill was going through Parliament. The Lords Committee considered that if Clause 17 of the Bill, which gave powers to the Assembly to make regulations for a redress scheme, were "conferred on a Minister in relation to England, it would be inappropriate, even if subject to affirmative procedure."[21] They noted that certain of the Bill's provisions in relation to Wales went wider than the arrangements in relation to England.

26. Many witnesses were concerned that the Measure did not go into sufficient detail as to how the scheme should operate and the Law Society suggested that the Measure should be accompanied by a full report on the policy from the Assembly Government, and the full text of the proposed regulations.[22] Cymru Yfory argued that:

> "The Assembly is entitled to expect the Assembly Government to have, and set out, clear plans for the use of powers to be conferred on it, especially when the powers proposed to be conferred are so broad."[23]

27. Despite strong views against the framework nature of the Measure some witnesses took a different view, commenting on the fact that the wide drafting of the Measure and the provision of much of the detail in regulations would allow flexibility, particularly as the scheme developed. The Wales Board of CHCs also argued that regulations would "enable all NHS organisations to have a single goal, to provide a standardised, consistent approach."[24]

28. The Minister made it clear to the National Assembly's Subordinate Legislation Committee that she did not consider the framework nature of the Measure would set a precedent and there were clear reasons why a framework Measure was appropriate in relation to the redress scheme. The Explanatory Memorandum sets out the case for the framework nature of the Measure explaining that the detail of the policy is currently under development and that:

> "for this reason the regulation making powers set out in the Measure are widely drawn to enable the results of this work to be taken into account in the drafting of the regulations."[25]

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[21] Written evidence, NHSR8
[22] Written evidence, NHSR31
[23] Written evidence, NHSR8
[24] Written evidence, NHSR20
[25] Explanatory Memorandum, paragraph 5.2

29. In its report on the Measure the Subordinate Legislation Committee stated:

> "The Committee accepts that there are valid reasons why a 'Framework' Measure is justified in this case, but considers that the approach taken by this particular Proposed Measure should not set a precedent; and recommends that the Minister ensures that the level of scrutiny provided by the Proposed Measure in relation to different kinds of Regulations is as strong as possible."[26]

30. We support the Subordinate Legislation Committee's view that there are valid reasons why a framework Measure is justified in this case and agree that there is a need for strong and thorough scrutiny of regulations coming forward from the Measure. We make recommendations in this regard later in this report.

31. We recognise that as the first Assembly Measure to have been scrutinised by a committee at Stage 1, the proposed NHS Redress Measure has attracted some criticism because of its framework nature. It is not unusual for legislation to confer regulation making powers on Ministers. However, we recommend that where future Measures take a similar approach in conferring wide regulation making powers to Welsh Ministers, they should be accompanied by a more detailed report on the policy behind the legislation to allow considered scrutiny by the Assembly. Furthermore, the policy should always have been developed before any proposed Measure is introduced into the Assembly.

Relationship of redress arrangements with the complaints procedure

32. Much of the evidence we received mentioned the need for greater clarity about the relationship between the current NHS complaints procedure and the proposed redress scheme. The Explanatory Memorandum refers to the redress scheme forming "one part of a set of integrated arrangements, which would also include the NHS complaints procedure"[27] but provides no further information.

33. The Medical Defence Union (MDU)[28] told us that, other than an award for compensation, the primary objectives under the scheme were already part of the complaints procedure and the Minister's objectives might be better achieved by enhancing the complaints system, allowing the focus to remain on complaints rather than compensation. They did not support a scheme that was a joined-up version of the complaints and claims procedure. They argued that a system that has financial compensation at its potential endpoint suffers the real risk that a patient entering the system with a complaint may feel their complaint has not been taken seriously unless they get financial

[26] Report from Subordinate Legislation Committee: Proposed NHS Redress (Wales) Measure 2007 (November 2007), paragraph 13
[27] Explanatory Memorandum, paragraph 1.1
[28] Written evidence, NHSR23

compensation. They also added that "if the endpoint were to be money, it is likely that a new group of complainants would enter the system… those whose motivation would be to get compensation."[29] They suggested that it would be possible to keep the two processes separate using the reports obtained in the complaints investigation to inform any claim for financial compensation.

34. The joint submission from the Medical Protection Society (MPS) and Dental Protection Limited (DPL) supported this view and said that the two systems should remain distinct and separate. They argued that access to the systems should be sequential with the complaints system being used to gather the facts of the case with the patient then free to seek redress or litigate through the courts. They concluded "the complaints procedure should only be a route into the redress scheme if harm has occurred that requires a remedy beyond an explanation or apology."[30]

35. AvMA put forward a different view claiming that the current process sends people down one road if they want an explanation and an apology and another if they also want financial compensation. They argued that the current system leads an NHS Trust to consider whether they can mount a credible defence to a claim rather than look at "whether they should have prevented this incident from happening in the first place, and how."[31] They concluded that the complaints process and redress arrangements should be integrated.

36. In addition, Welsh Health Legal Services (WHLS)[32] were concerned that decisions would be made on redress arrangements before the Speedy Resolution Scheme pilot had been evaluated. The Speedy Resolution Scheme was set up by the Welsh Assembly Government and aims to provide a claims procedure for quick resolution of claims for clinical negligence against Welsh NHS Trusts. Claims between £5,000 and £15,000 are eligible for the Scheme. The Scheme also encourages Welsh NHS Trust to provide apologies if it transpires that the medical treatment received fell below the required standard.

37. The Minister indicated that the Speedy Resolution Scheme would continue, providing an element of choice for patients, but it was not clear to us how the Speedy Resolution Scheme fitted into the process and whether there would be a need for it once a redress scheme is in place.

38. The Speedy Resolution Scheme is being evaluated at present and the Investigations and Process Working Group did not consider it in any detail, other than recognising that if it were to continue it would provide an additional choice for patients.

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[29] RoP, paragraph [11], 25 October 2007
[30] Written evidence, NHSR24
[31] RoP, paragraph [57], 25 October 2007
[32] Ibid., paragraph [117]

39. It is not clear from the Measure or the Explanatory Memorandum what the relationship will be between a complaints procedure and the proposed redress scheme. However the Minister told us that she believed the complaints process and redress arrangements should be integrated, providing patients with a seamless approach.

40. The Investigation and Process Working Group considers that "Investigation processes for complaints, claims and patient safety incidents can and should be aligned, with the basic approach to the investigation being to 'do it once, do it early and do it well."[33] They anticipate a single investigation which could then lead to a number of options for providing remedy where appropriate, and where liability in tort has been identified, this could mean redress under the proposals in the Measure, the Speedy Resolution Scheme (if it continues), or the traditional litigation route.

41. We accept the argument that the complaints procedure and any redress arrangements should be integrated to ensure that they provide a positive outcome for both patients and health professionals. We note the comments made in the Investigation and Process Working Group report regarding aligning the investigation processes and would expect much more detail in their final report to inform the drafting of the regulations.

42. We recommend that the Minister ensures there is complete clarity in the regulations as to how the complaints procedure and the Speedy Resolution Scheme will work alongside any redress arrangements.

43. We recommend there should also be sufficient safeguards built into the redress arrangements to ensure that patients who do not receive a financial award do not feel that their complaint was any less valid than a patient who did.

No-Fault schemes

44. The Measure only makes provision for a redress scheme where there is a qualifying liability in tort. In the statement in plenary on the proposed Measure on 3 July 2007[34] some Members asked whether the Assembly Government should seek wider powers to enable them to introduce a 'no-fault' scheme. We also asked a specific question in relation to this in our consultation.

45. We were told that the phrase 'no-fault' is possibly something of a misnomer as there are a wide range of schemes throughout the world that are often described as 'no-fault' schemes, but generally they all use some form of assessment or test to ascertain whether compensation should be paid in relation to an incident.

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[33] Annex E

[34] RoP, Record of Plenary Proceedings, 3 July 2007, which can be found at: http://www.assemblywales.org/bus-home/bus-chamber/bus-chamber-third-assembly-rop.htm?act=dis&id=55675&ds=7/2007#rhif3

46. There was a mix of views about whether the Assembly should seek further powers to introduce a no-fault scheme and in general the views of respondents to the consultation were somewhat polarised.

47. The BMA were strongly in favour of a no-fault scheme arguing that the present tort-based procedures "destroy the proper relationship between patient and doctor, introducing a confrontational element, totally foreign to the mutual trust which should exist."[35]

48. AvMA supported this view stating that "restricting eligibility for redress under the scheme to cases that would qualify as a liability in tort would be a huge wasted opportunity."[36] They argued that retaining liability in tort as the qualifying test for redress "would not move things forward much from where they are now"[37] They argued for an "avoidability test" which is explained at paragraph 78.

49. The Medial Defence Union provided comprehensive detail on the considerations for introducing a no-fault scheme but concluded that "there may be legal difficulties… in attempting to provide compensation on a no-fault basis for a small and clearly defined sector of society."[38] They did, however, support the introduction of such a scheme, UK-wide for babies with neurological damage.

50. The National Pharmacy Association did not support a no-fault scheme and Hutton's solicitors[39] referred to the Chief Medical Officer's report Making Amends which concluded that a 'no-fault' scheme was unaffordable.

51. Whether they supported a move to a 'no-fault' scheme or not, most of the respondents who commented recognised that a great deal of further investigation would need to be carried out before moving away from a test of liability in tort.

52. Given the evidence we have received in relation to no-fault based schemes we conclude that this should not be explored at present. A great deal of further work and investigation would need to be carried out before decisions were made on anything other than a tort based scheme of redress.

[35] Written evidence, NHSR5
[36] Written evidence, NHSR19
[37] Ibid.
[38] Written evidence, NHSR23
[39] Written evidence, NHSR26

6. SPECIFIC COMMENTS ON THE MEASURE

Scope of the redress scheme (Sections 1 & 2)

53. Section 1 of the Measure makes provision for Welsh Ministers to make regulations to enable redress to be provided, where a qualifying liability in tort arises, without having to go to court. It sets out the bodies and persons any redress arrangements will apply to as:

- an NHS Trust in Wales;
- a Local Health Board;
- a Special Health Authority;
- the Welsh Ministers; and
- any body or person providing, or arranging for the provision of, services in Wales as a result of an arrangement with any of the above bodies.

54. This means that general practitioners; dentists, pharmacists and ophthalmologists providing NHS care or independent hospitals commissioned to provide care as part of the NHS may incur liability, i.e. the primary care sector.

55. Section 2 sets out the type of provision Welsh Ministers may make in respect of a redress scheme. The regulations must provide for:

- an offer of compensation;
- a written explanation;
- a written apology; and
- a report on action taken to prevent similar cases arising.

56. Redress arrangements must not apply to a case which is already or which has been the subject of legal proceedings. Any regulations which provide for financial compensation may specify an upper limit of that compensation and if no such limit is specified must specify an upper limit on the amount to be offered in respect of pain and suffering. This section of the Measure also makes provision for compensation to be offered in the form of remedial treatment in addition to any financial compensation.

57. From the evidence we received, it seems clear to us that the redress arrangements are welcomed in so far as they apply to secondary care and in relation to the form of redress available under the Measure. We did, however, receive evidence that reflected considerable concern about the inclusion of primary care under the scheme and on the impact that the proposed redress arrangements might have on healthcare professionals.

Inclusion of primary care under the redress scheme

58. The Measure enables the redress scheme to apply to be applied to the primary healthcare sector in addition to secondary care. Section 1(5) of the Measure allows Welsh Ministers to specify in regulations the 'qualifying' health

services to which the redress scheme will apply. There is no limitation placed on what Welsh Ministers might include in the description of 'qualifying services'.

59. The Explanatory Memorandum states, however, that Welsh Ministers could decide to introduce the scheme to secondary care initially and to delay the regulations that would extend the scheme to primary care.[40] The Memorandum suggests that such a delay would allow more time to work out the practical details of applying the scheme to primary care and to conduct the necessary negotiations with the contractor professions and their insurance providers.[41]

60. We received a range of evidence on the inclusion of primary care services under the redress scheme. Some respondents referred to the need for consistency across all NHS services, whilst others considered that the current complaints procedures for primary care worked well and there was no need to change them.

61. The Royal College of Nursing Wales (RCN) referred to the benefit of a one-size fits all approach and stated that: "it would be helpful from the point of view of patients and practitioners, in both primary and secondary care, if a consistent system was applied across the board, so that everybody was informed about the process for raising concerns and complaints."[42]

62. Bro Morgannwg NHS Trust suggested that if the scheme did not include primary care then it could be seen to be inequitable. They told us that: "from a patient's perspective, if you believe that you have been the subject of a medical mishap, why should you be treated differently if that happened as a consequence of primary care as opposed to secondary care?"[43] Similarly, AvMA considered that "if you are getting NHS treatment, the man and woman on the street would expect to have the same rights and the same access to redress wherever they were receiving their NHS treatment."[44]

63. A number of primary care organisations told us that they were not supportive of the proposals for the scheme to apply to primary care. BMA Cymru[45] said that the current professional indemnity arrangements for primary care work effectively and there is little, if any, need for this to change. Optometry Wales[46] and the National Pharmacy Association[47] agreed and saw no reason for the scheme to include community optometrists and pharmacists.

[40] Explanatory Memorandum, paragraph 5.8
[41] Ibid.
[42] RoP, paragraph [29], 16 October 2007
[43] RoP, paragraph [61], 11 October 2007
[44] RoP, paragraph [89], 25 October 2007
[45] Written evidence, NHSR5
[46] Written evidence, NHSR6
[47] Written evidence, NHSR17

64. Dental Protection Limited,[48] the dental arm of the MPS, referred to the fact that dental treatment is often a mix of NHS and private treatment and suggested that this could pose particular problems for any redress scheme that was exclusively for NHS healthcare.

65. Whilst AvMA valued the consistent approach across all healthcare services, they recognised that there could be major issues around the inclusion of primary care and stated that there are lots of difficult problems to be overcome if that is to be achieved. Despite these difficulties, however, they stated that:

> "we would not want to see the work around moving the scheme into primary care simply shelved to be looked at again at some point in the future. The work should be started now, to identify the issues."[49]

66. Community Pharmacy Wales[50] suggested that there are major issues surrounding clinical governance and how the proposed Measure ties in with professional performance, fitness to practice and other professional regulatory issues. BMA Cymru considered that "without the details of how the scheme will operate in practice it is difficult to see how these issues will be satisfactorily resolved and sufficient safeguards for the practitioner incorporated within the scheme."[51]

67. Witnesses referred to the particular indemnity arrangements for GPs and suggested that the scheme could be trialled in the secondary care setting initially. A number of organisations considered that a trial of three years could help to determine whether it would be necessary or appropriate to introduce a similar scheme in primary care. [52] The Royal Pharmaceutical Society of Great Britain[53] called for the experience of implementing the scheme in secondary care to be carefully evaluated prior to any further strategy of extending the scope of the Measure.

68. The Minister accepted that different structures exist in primary and secondary care settings and expressed her commitment to consult relevant primary care stakeholders on these issues. She confirmed that it was her intention to launch the scheme in the secondary care sector first before considering whether it should be expanded to include primary healthcare. The Minister indicated that she had still to give consideration to how long the trial period should last but said that the scheme would not be expanded in this way before 2009.

69. In its interim report, the Investigation and Process Working Group recognised that the extension of any redress arrangements to include primary care will require additional work with input from local health boards and

[48] RoP, paragraph [111], 11 October 2007, written evidence, NHSR24
[49] RoP, paragraph [88], 25 October 2007
[50] Written evidence, NHSR4
[51] Written evidence, NHSR5
[52] Written evidence, NHSR4; written evidence, NHSR23; written evidence, NHSR24
[53] Written evidence, NHSR18

primary care practitioners. The Group suggested that "the different indemnity arrangements, the mix of NHS and privately provided care as well as the business-focussed provision of services across the primary care sector will have to be carefully considered before this element can be progressed further."[54]

70. We are concerned about the range of issues raised in evidence with regard to the inclusion of primary healthcare under the redress arrangements and we welcome the Minister's assurance that the redress scheme will not include primary care at the outset.

71. We recommend that before any decision is taken to expand the redress arrangements to include primary care a full evaluation is conducted of the scheme's operation in the secondary care setting. We also recommend that the Minister should carry out a full and thorough consultation with stakeholders on any proposed expansion of the scheme to include primary healthcare and that this should take place prior to the drafting of the relevant regulations.

Impact on health professionals

72. Section 1(4)(a) of the Measure provides that liabilities in tort must be in respect of an injury or loss arising out of a breach of duty of care, and specifically provides that this liability will be owed as a result of an act or omission by a health care professional (or other body or person as may be specified in regulations – section 1(4)(b)).

73. We have received much evidence expressing concerns in relation to the impact of the proposed scheme on healthcare professionals. The RCN suggested that, if not handled carefully, the redress scheme could potentially discourage healthcare professionals from reporting mistakes. They argued that it was important for nurses to have confidence in the investigations process saying that:

> "what was not clear… is the point at which an investigation is commenced, who will initiate that investigation, whether or not the professionals, namely nurses in our case, will be represented, and where the apology will come from." [55]

74. It was put to us by many witnesses that it would be helpful if there was an acceptance that most errors occur through systems failings but that in practice there is still a culture of blame and of attributing errors to an individual practitioner.

75. The Medial Defence Union commented further on this, in particular referring to the need, where it is identified that an adverse incident arises from a systemic failure, that "there is no blame attributed to individual

[54] Annex E
[55] RoP, paragraph [15], 16 October 2007

clinicians in circumstances where what we are really looking at is a systems error."[56] They also expressed concerns about how the investigations process would be handled and the need for those delivering it to understand that clinicians should be involved at the start of any complaints process especially where it is likely that the outcome will include the clinician's involvement in the patient's ongoing care.

76. The Welsh NHS Confederation said that:

> "no-one involved in healthcare will expect to be completely free of blame if something has gone wrong and it is their fault, but the important thing is the methods by which they are dealt with and how people can be trained and developed to ensure that a situation does not happen again."[57]

77. AvMA recognised the dangers for practitioners in the process, acknowledging that:

> "Sometimes, a clinician just happens to be the last one in the chain of a system error, where the system as a whole has failed the patient, but that clinician is the one pinpointed… and stigmatised by that label of being 'negligent'."[58]

78. They proposed an "avoidability test" which would ask the question "could the adverse outcome have been avoided if the organisation responsible for the treatment had followed accepted good practice?"[59] They suggested that this would signal a move away from a perceived blame culture and focus on root causes and systems issues. It could have the added advantage of ensuring outcomes of individual investigations provide answers needed to improve patient safety.

79. The BMA were concerned that having the trust investigate a complaint rather than an independent body might lead to pressure on a practitioner to admit liability so that the matter could be settled quickly. They highlighted the unintended consequences of investigations for practitioners with regard to their career saying that:

> "it would be at the expense of the practitioner who would have to accept liability, which would have, these days, very considerable consequences for that practitioner's career and career progression."[60]

80. The Minister agreed there was a need for safeguards within the scheme and for support mechanisms for healthcare professionals. She maintained that "they [staff] must have certainty that their professionalism is not being

[56] RoP, paragraph [32], 25 October 2007
[57] RoP, paragraph [152], 25 October 2007
[58] RoP, paragraph [55], 25 October 2007
[59] Written evidence, NHSR19
[60] RoP, paragraph [138], 11 October 2007

questioned and that they are not being hounded under any new systems."[61] She also emphasised the importance of the quality of local investigations so that they can uncover system failures and what might be attributable to individual mistakes. She was not able to provide further information at this stage on how this might work in practice but was seeking advice from health professionals and professional bodies to deal with these issues.

81. It is clear from the evidence that there is a great deal of concern about the impact redress arrangements might have on health professionals. Clearly redress arrangements will not work effectively if health professionals feel there are barriers to them being open about adverse incidents. **We recommend the Minister considers this area carefully and ensures that sufficient safeguards are built into the arrangements to ensure that NHS staff have confidence in the systems and are protected from unintended consequences.**

82. It is clear to us that the quality and handling of investigations is key in this regard and we make further recommendations about investigations later in this report.

Compensation limits

83. The Measure provides that the regulations may specify an upper limit for compensation, and if no such limit is specified must specify an upper limit on the amount to be offered in respect of pain and suffering.

84. While most witnesses agreed that a limit for financial compensation should not be set in the Measure many commented that the redress arrangements should apply to claims up to around £20,000. This is the figure being considered in relation to the redress scheme in England and witnesses suggested it would be sensible for there to be consistency particularly where cross-border treatment may have been provided. An upper limit of £20,000 was supported by the Legal Advice Working Group but they considered this to be an area where further work needs to be carried out in order to consider the full range of options.[62]

85. LSC argued that the maximum level of compensation should be "consistent with enabling as many claimants as possible to either pursue redress under the scheme or with the benefit of public funding."[63] They suggested that this level should be set at £30,000 to ensure that cases with "good" prospects do not fall between redress arrangements and public funding.

86. AvMA suggested that while there might be an upper limit, for the time being at least, there should be flexibility within the scheme where both sides agree to higher settlements being considered under the scheme. They did not

[61] RoP, paragraph [67], 25 October 2007
[62] Annex E
[63] Written evidence, NHSR11

agree that a limit should be put on the amount that could be awarded for pain and suffering. They argued:

> "If the scheme uses the definition of liability in tort and is to be a credible alternative to legal action, it must award damages which it would be expected would be awarded by a court of law."[64]

87. Carmarthenshire County Council asked who would review tariffs and how they would be amended in the light of developments in medical science. They also said it would be "helpful to have an annual review of tariffs and how the scheme is working tied into the production of annual statistics."[65]

88. We consider that it is appropriate for the limits for compensation to be set in regulations rather than in the Measure to ensure there is flexibility in the scheme.

89. We recommend the Minister considers in further detail the level of the upper limit for compensation and, in particular, the view put forward regarding the danger of setting too low a limit which could mean that some cases may fall outside the redress scheme, but may not be eligible for public funding to take forward a case through the courts. The upper limit for compensation will impact on the type and number of cases which are eligible for redress arrangements and this is an area where we would expect the Minister to provide further information for the Stage 1 debate.

Investigations under the scheme (Sections 4 & 5)

90. The Measure makes provision for Welsh Ministers to make regulations setting out how the redress arrangements will operate. Section 4 places a duty on NHS organisations to proactively consider cases for potential redress. Section 5 concerns the delivery of redress arrangements including the conduct of investigations and reporting the findings of investigations. As section 5 deals with more general issues surrounding investigations, this is discussed first.

91. The Explanatory Memorandum suggests that one of the specific benefits of the proposed redress scheme will be more effective investigations; investigations will be conducted earlier and better.[66] In the Memorandum, the Minister recognises that it will be of great importance to develop the skills of staff to be able to undertake proper investigations and that there will be significant costs associated with this.[67]

[64] Written evidence, NHSR19
[65] Written evidence, NHSR21
[66] Explanatory Memorandum, paragraphs 7.14 and 8.12
[67] Ibid., paragraph 8.13

Conduct of investigations

92. The regulation making powers conferred on the Welsh Ministers in section 5(2) include provision regarding the investigation of applications for redress (including the overseeing of the investigation by an individual of a specified description).

93. From the evidence received, it is clear that many respondents believed thorough investigations to be a vital element in determining whether the proposed redress scheme will operate effectively. We heard from MDU that:

> "it is important that decisions taken about awarding compensation under the scheme are made after thorough investigation, with appropriate involvement of the clinician(s) concerned and in the light of appropriate expert evidence."[68]

94. The MPS suggested that at the core of whether the scheme is working well and has the confidence of those involved, is the competency of those conducting investigations.[69]

95. Other evidence referred to the need for investigations to be conducted independently. BMA considered that for the system to be fair, practitioners would like to have investigations conducted independently from NHS Trusts. They suggested that:

> "conducting investigations in this way would better allow any investigation to look not only at the practitioner's clinical skill and whether it was wanting, but also at whether the trust's management system was also at fault or could be improved."[70]

96. AvMA highlighted the importance of ensuring that there are sufficient safeguards, checks and balances inherent in the investigative process to ensure that investigations are conducted properly. They suggested that there may be certain points at which it would be helpful to involve independent medical experts in the process, such as in the Speedy Resolution Scheme. Alongside that, it may be necessary to ensure that where appropriate patients get advice and possibly representation through the process.[71] The provision of advice and assistance under the scheme is discussed at paragraphs 132-154.

97. The Minister stressed the importance of carrying out detailed and thorough investigations and stated that the effectiveness of the scheme will rely on the quality of these investigations.

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[68] Written evidence, NHSR23
[69] RoP, paragraph [118], 11 October 2007
[70] Ibid., paragraph [138]
[71] RoP, paragraphs [72], [80] and [81], 25 October 2007

Time limits

98. Section 5(2) also includes regulation making powers regarding time limits and any extensions of them in relation to acceptance of an offer of compensation. There is, however, no provision for time limits to be specified as part of the investigations process. We received evidence that suggested that there should be.

99. The Law Society told us that robust time limits are needed because:

> "if a claim develops a life of its own the whole process will be undermined. Therefore, we think that there should be rules about time limits. The trusts should welcome that as much as the claimant's solicitor in ensuring that the investigation does not drag on."[72]

100. The Law Society suggested that if you had an independent investigator then it would be easier to impose time limits because they would come to it totally independently of both parties.[73] They also referred to the time limit of six to nine months for the handling of a case under the Speedy Resolution Scheme and suggested that the time limit is the key factor that makes the speedy resolution scheme attractive to patients.[74]

101. RCN Wales also suggested that the inclusion of timelines under the scheme could help clarify the process and would benefit patients and healthcare professionals alike.[75] The Wales Board of CHCs suggested that building time limits into the scheme would bring confidence into the system.[76]

102. Bro Morgannwg NHS Trust supported the suggestion of a two-stage process where, firstly, the decision on whether there is a case to answer is taken within a certain time frame. The second stage, which involves more detailed investigation of the effect of any failures and the impact on the patient, could allow for more flexibility.[77]

103. The Minister was supportive of including time limits as part of the working group's consideration. Specifically, the Minister indicated that she was broadly supportive of the concept of establishing a set time limit from the initiation of a complaint to the point that a settlement is offered.

Training and skills

104. The Explanatory Memorandum recognises that "developing the skills of staff to be able to undertake appropriate investigations will be of great

[72] RoP, paragraph [83], 16 October 2007
[73] Ibid., paragraph [93]
[74] Ibid., paragraph [84]
[75] RoP, paragraphs [53] and [54], 16 October 2007
[76] RoP, paragraph [37], 2 October 2007
[77] RoP, paragraph [10] and [12], 11 October 2007

importance, both in terms of building on existing skills and experience, and the acquisition of new areas of expertise."[78]

105. In evidence, we heard that if investigations are to be conducted within the NHS then a substantial amount of staff development and training will be required. WHLS[79] considered current staffing levels in the NHS to be inadequate for the proposed scheme to work effectively and the Welsh Risk Pool[80] said that claims and complaints management has been consistently undervalued in organisations.

106. The Wales Board of CHCs called for more consistency in how investigations are undertaken and the need for staff undertaking such investigations to be properly trained and qualified.[81] The MDU stated that:

> "people would have to be trained to know what expert advice to get, what information they would require, how to conduct a proper investigation, and how to get evidence from all those who were a part of the sequence of events."[82]

107. Blaenau Gwent Local Health Board suggested that a dedicated team attached to one organisation in each NHS region could be tasked to assess cases of financial redress and whether payments should be made.[83]

108. The Minister recognised that further investment in staff training will be required to ensure that there is sufficient expertise available to conduct investigations under the proposed redress scheme. The Minister told us that the working group is currently looking at the detail of what skills and training needs might be required.

Findings of working groups - interim reports

109. In their interim report the Investigation and Process Working Group suggests that a common culture needs to be developed towards investigations in the NHS. The Group states that this common approach should be reflected within NHS bodies' structures and lines of accountability and that this should be promoted at Board level. Before its final report, the Group expects to look in further detail at developing specific recommendations for the operation of the investigations process, including timescales and the staff resources, skills and training that will be needed.

110. In its interim report, the Group emphasises the need for a single investigations process for complaints, claims and patient safety incidents. They suggest that undertaking "one investigation which can fully and appropriately deal with all of the issues raised, rather than multiple

[78] Explanatory Memorandum, paragraph 7.18
[79] RoP, paragraph [120], 25 October 2007
[80] Ibid., paragraph [122]
[81] RoP, paragraph [34], 2 October 2007
[82] RoP, paragraph [21], 25 October 2007
[83] Written evidence, NHSR14

investigations under different procedures, should ensure that neither patients nor healthcare staff have to endure protracted, sometimes multiple and open-ended investigations."[84] The Group states that conducting investigations of this nature will require NHS bodies to ensure adequate resourcing with staff who possess the necessary skills, expertise and competence and that these staff must be of an appropriate level of seniority or be able to easily access senior support."[85]

111. The Group also considered the option of introducing an overall time limit of 12 months for the investigation of cases under the redress scheme. The Group's report states that "whilst it was agreed that this might be a useful working assumption, the group felt that more work needed to be done, in conjunction with the Legal Advice Working Group, to determine a realistic overall timescale for this element of the process."[86]

112. We recognise the important part that the investigations process will play in contributing to the success of the redress scheme. This is reflected by the strength of opinion that we received in evidence.

113. The investigations process is key to the success of any redress arrangements and we urge the Minister to ensure that the detailed evidence we have received on the investigations process is taken into account by the working group and during the formulation of the relevant regulations.

114. We consider that interim time limits are required to ensure that both patients and NHS staff have confidence in any redress arrangements. We consider that it is appropriate for these time limits to be set out in future regulations under the Measure. We recommend, however, that the Measure should be amended to require that regulations must make provision for time limits in relation to the investigations process.

Withholding of investigation reports

115. Section 5(3) requires that Welsh Ministers must make regulations requiring the findings of any investigation to be recorded in a report and for a copy of that report to be available to the individual seeking redress. The Measure also provides that a report need not be provided in certain circumstances.

116. Evidence received on this issue reflected two main viewpoints. Those who considered that the investigative and reporting process must be absolutely transparent suggested that investigation reports should always be disclosed. Others suggested that there could be certain circumstances where it might not be helpful to disclose the full report to a claimant.

[84] Annex E
[85] Ibid.
[86] Ibid.

117. The Wales Board of CHCs told us that "an investigation should be a fact-finding exercise, which should be open and transparent and we should all be able to scrutinise who they spoke to, where the statements came from and how they achieved those statements."[87] AvMA considered that it should be a fundamental right of any person whose case has been the subject of an investigation to receive the report.[88]

118. The Law Society considered that in order for legal advisers to be able to assess the appropriateness of an offer they must have access to the documentation on which the claim is based. They believe that this is fundamental to the success of the redress arrangements and suggested that anything less will not have the trust or confidence of potential applicants. [89]

119. We heard evidence, however, that it could be appropriate to withhold a report, in certain circumstances. The MPS suggested that disclosure might not be appropriate where there is a risk that the information might pose a threat of serious harm to the health or welfare of an identifiable individual.[90] The Wales Board of CHCs suggested that reports could be withheld where they might cause harm in relation to mental health cases.[91]

120. Carmarthenshire County Council told us, however, that in some circumstances where there is a risk of harm, it might be more appropriate to provide an amended report to the complainant rather than a blanket refusal to disclose the report.[92]

121. The Minister indicated that she is supportive of considering further whether investigation reports could be withheld under certain exceptional circumstances.

122. We are concerned that the Measure does not emphasise the importance of disclosing information to the complainant.

123. Whilst we recognise there may be circumstances where it may be appropriate to withhold information from a complainant, we consider such cases should be exceptional.

124. We recommend that the Measure should be strengthened to prescribe that investigation reports will normally be disclosed and that they may only be withheld in exceptional circumstances. Safeguards should also be included in the Measure to ensure that any decision to withhold an investigation report should be reviewed by a body which is independent of the NHS organisation that is concerned in the case.

[87] RoP, paragraph [134], 2 October 2007
[88] Written evidence, NHSR19
[89] Written evidence, NHSR31
[90] RoP, paragraph [101], 11 October 2007
[91] RoP, paragraph [132], 2 October 2007
[92] Written evidence, NHSR21

Duty to conduct inquiries

125. Section 4 confers on the Welsh Ministers regulation making powers to place a duty on a body or person who is investigating or reviewing a case to proactively consider whether there is potential liability and a case for redress.

126. A relatively small number of witnesses commented on how a duty to investigate might work in practice. The Welsh NHS Confederation[93] and Bro Morgannwg NHS Trust[94] indicated their strong support for the principle that an investigation should proactively consider what redress may be appropriate and to open communication with the patient accordingly. The NHS Trust suggested that:

> "If regulations do not require these steps, it could be viewed that the onus remains unfairly placed on patients to know when there may be a potential right of action and to pursue it. The question must be asked whether this fits with a healthcare system that should be open and honest with the patients it serves and is perceived to act accordingly."[95]

127. Citizens Advice Cymru suggested that such an open approach to reporting mistakes would signal a huge cultural change.[96] RCN Wales referred to the culture of blame that exists in the NHS and suggested that the proposed scheme needs to recognise that most errors are systemic, often having to do with staffing levels and poor communication between clinical staff.[97] They suggested that if nurses could feel confident that this would be the culture that would be introduced then they would be very happy to raise their concerns about an incident which had occurred on a ward.[98]

128. The Minister was unable to provide us with any information about who this duty would fall on and who would advise patients if a case was considered eligible for redress. The Minister stated that she intended to consult further on the operation of this provision.

129. The Investigation and Process Working Group considered that where "things have gone wrong, NHS bodies should be honest and focus on what is a fair outcome for the patient/family in the circumstances. Where it is fair and appropriate, NHS bodies should feel able to make an offer of redress whether or not a patient has made a formal claim."[99]

130. We welcome the inclusion in the Measure of the duty on NHS organisations requiring the proactive investigation and assessment of cases.

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[93] Written evidence, NHSR34
[94] Written evidence, NHSR30
[95] Ibid.
[96] RoP, paragraph [142], 2 October 2007
[97] RoP, paragraph [20], 16 October 2007
[98] Ibid., paragraph [21]
[99] Annex E

131. We remain concerned about the lack of detail about how the provisions will operate and call for the Minister to make it clear in the regulations where the duty to conduct inquiries falls and how it will be enforced and monitored. We would expect the Minister to provide further information on this for the Stage 1 debate.

Advice and assistance under the scheme (Sections 7 & 8)

132. The Measure seeks to assist patients with legal advice and general assistance under the proposed redress scheme. Section 7 specifies that Welsh Ministers may make provision in regulations for the provision of free legal advice and other services, such as medical expert opinion, to claimants.

133. Section 8 of the Measure allows for Welsh Ministers to make provision for other forms of assistance to individuals and to make payments. The Explanatory Memorandum describes such assistance as different from that offered in section 7 in that it is more akin to general assistance or advice for people who feel that they want to talk through their situation before taking further action.[100]

134. The Explanatory Memorandum highlights the provision of legal advice and advocacy support without charge as one of the specific benefits of the proposed redress scheme.[101] The Minister has appointed two working groups under the Putting Things Right project to identify the mechanisms by which advice and assistance might be provided under the scheme and the likely costs of doing so.[102]

135. In their evidence various organisations welcomed the proposals to provide legal advice and assistance under the scheme. Evidence also, however, highlighted the lack of information on the structure of how such advice and assistance would be provided.

136. AvMA considered access to legal advice without charge to be an absolute necessity under the scheme.[103] Both the LSC[104] and The Law Society[105] welcomed the proposals in section 7, but called for greater clarity about the extent of such advice. Similarly, Citizens Advice Cymru told us that it is not clear who will provide the assistance to patients under section 8 of the Measure.[106]

137. Much of the evidence we received referred to a number of key areas which should be taken into account as part of the formulation of the regulations regarding advice and assistance under the scheme. The main

[100] Explanatory Memorandum, Annex: Explanatory Notes, paragraph 19
[101] Explanatory Memorandum, paragraph 7.14
[102] Letter from Minister for Health and Social Services to Committee Chair, dated 10 October 2007, Annex C
[103] Written evidence, NHSR19
[104] Written evidence, NHSR11
[105] Written evidence, NHSR31
[106] Written evidence, NHSR3

areas of consideration related to when support should be made available, i.e. are there key stages where it is particularly required, and who should provide the advice and assistance? Some evidence referred to the need for legal advice to be provided by specially trained legal experts, whilst other evidence focused on engaging independent expert advisers in the redress process.

138. Wales Council for Voluntary Action (WCVA) strongly expressed the view that advice and support for patients under the redress arrangements is provided at all stages of the process. WCVA was concerned that the provision of free legal advice and other expert advice and advocacy support is specified as being available only as Minister's see fit. They said that "free advice and support is needed at all stages of the process and should not be reliant on Ministers deciding if the need for such support is valid."[107]

139. The Law Society suggested that claimants should be entitled to legal advice without charge at key stages throughout the process. To do otherwise, the Society argued, would erode the complainants right of access to justice under the scheme.[108] In particular, the Society considered that it would not be fair for a victim to be required to agree settlement terms without appropriate legal advice.[109]

140. The Wales Board of CHCs focused on the value of providing advice and assistance to patients at the start of the redress process. They considered that there is a danger that patients can get lost in the process and so it would be more helpful for patients to receive guidance and to have an opportunity to talk through the process right at the beginning.[110]

141. The timing of when advice and assistance is provided under the scheme is clearly a complex issue, which WHLS referred to in the context of the work of the Legal Advice Working Group. We heard that:

> "there is unlikely to be an agreement between us as to how much legal advice is needed, because there is no doubt that those lawyers who provide legal advice in clinical negligence claims consider it to be essential at nearly every stage to ensure that the patient has been adequately heard and represented. That is unlikely to change."[111]

142. Other evidence highlighted the need for legal advice and assistance to be provided independently and by those with relevant expertise. The LSC called for advice to be provided independently of the NHS. The Commission was concerned that under section 9(2)(d) of the Measure regulations could permit NHS Wales itself to provide advice under the scheme. [112] The Wales Board of CHCs also told us that it is essential that advice and support is recognised by the complainant as independent of the NHS. They said that this

[107] Written evidence, NHSR12
[108] Written evidence, NHSR31
[109] RoP, paragraph [68], 16 October 2007
[110] RoP, paragraph [49], 2 October 2007
[111] RoP, paragraph [129], 25 October 2007
[112] Written evidence, NHSR11

independence is essential in giving patients and the public confidence in the support and advice that they receive.[113]

143. The Law Society[114] and LSC[115] referred to the need for solicitors to be accredited under the Clinical Negligence Accreditation Scheme or to be employed by AvMA. They considered that this would ensure that victims receive expert legal advice from specialists with relevant expertise in dealing with clinical negligence matters.

144. Other evidence highlighted the value of involving independent medical advisers in the redress process. AvMA told us that it would like to see a more specialist source of advice and support, which need not necessarily be full-blown legal representation, but which could certainly be more knowledgeable and specialist in clinical and legal issues.[116] Bro Morgannwg NHS Trust also commented that it finds the input of independent expert advice helpful in certain circumstances, for example, where clinicians are unable to reach a consensus, or where external, independent opinion is seen as the only way of satisfying the complainant.[117]

145. The Welsh Risk Pool suggested that it would be worth considering involving advisers other than fully qualified legal professionals in the scheme. They suggested that "solicitors may see the scheme as a repository for those cases which they would not normally consider taking forward by traditional means and so, costs may be incurred in cases which would otherwise have been filtered out by the current system."[118] WHLS also commented that trained mediators could be more involved in the redress process and that this could obviate the need for legal advice for those whose understanding of the process is sufficient.[119]

146. WHLS also commented on the lack of provision for the supervision, monitoring and audit of legal service providers in the Measure.[120] With regard to the use of independent advisers under the scheme, the Welsh Risk Pool suggested that mechanisms to carefully control training, assess competence and monitor performance would need to be introduced.[121]

147. The Minister confirmed that the provision of legal advice and assistance under the scheme is the subject of consideration by two working groups which are part of the Putting Things Right project.

148. The Minister referred to the expertise of a number of organisations which could be involved in providing advice and assistance under the scheme

[113] Written evidence, NHSR20
[114] Written evidence, NHSR31
[115] Written evidence, NHSR11
[116] RoP, paragraph [76], 25 October 2007
[117] RoP, paragraph [43], 11 October 2007
[118] Written evidence, NHSR33
[119] RoP, paragraph [131], 25 October 2007; written evidence, NHSR32
[120] Written evidence, NHSR32
[121] Written evidence, NHSR33

such as WHLS, Welsh Risk Pool, the CHCs and Citizens Advice Cymru. These organisations are all involved in the project working groups. The Minister was, however, unable to provide any further details of how advice or assistance might be provided under the scheme.

Findings of working groups – interim reports

149. In their interim report, the Legal Advice Working Group recognised that legal advice is necessary in that it will provide patients and NHS bodies with independent advice and quality assurance regarding investigation and any offer of settlement.[122] The Group considered that advocacy should be available in addition to legal advice under the redress arrangements and suggested that patients should not be precluded from using one service where the other is involved.

150. The Group's report referred to the specific issues of when legal advice should be provided under the scheme and who should provide this service. Whilst the Group considered that some claimants would prefer to receive greater legal assistance compared to others, there are a number of key stages when such input should be available. The Group highlighted the following key stages: at the conclusion of an investigation undertaken by an NHS trust; where a breach of duty is accepted, but causation and/or prognosis of the patient requires further expert opinion; where an NHS trust has made an ex gratia offer without making an admission of liability; or where an offer of settlement is made.

151. The Group also considered who should provide such legal advice under the redress arrangements. It concluded that specialist clinical negligence solicitors - recognised members of AvMA or The Law Society Clinical Negligence panel – are the most appropriate in order to ensure consistency and quality assurance of the advice provided.

152. The Advocacy and Assistance Working Group also considered elements of the provision of advice and assistance, focusing on advocacy and support services for patients, under the redress scheme.[123] The Group recognised that Citizens Advice Cymru, Community Health Councils and AvMA have expertise in this area. In its interim report, the Group made a number of recommendations including the use of independent mediation services where appropriate and the introduction of a memorandum of understanding to ensure that the communication, information and assistance provided to patients is consistent across all organisations. The Group also recommended that, irrelevant of whether legal advice has been accessed, advocacy and assistance should be available to the patient throughout the pathway of a complaint.

153. We recognise the importance of providing clear, consistent advice and information to patients under the redress arrangements and we

[122] Annex E
[123] Ibid.

welcome the commitment to provide advice and assistance free of charge as part of the redress scheme.

154. We note the interim findings of the working groups on this issue and call for the Minister to provide further details on the operation of these provisions for the Stage 1 debate. In particular, we seek clarification from the Minister on when advice and assistance will be accessible under the scheme, who will provide such advice and assistance and how these services will be monitored to ensure consistency of approach.

Structure of the scheme (Section 9)

155. It is not clear from the Measure what the structure of the scheme will be or how it will be monitored and managed. The NHS Redress Act 2006 which applies in relation to England sets out that there will be a "Special Health Authority" (referred to as "the scheme authority"). That Act makes provision for its membership and sets out its specific functions.

156. Section 9(2) of the Measure does make provision for the regulations to provide for persons or bodies to have functions similar to those of the "scheme authority" in the UK Act; accessing redress, making payments, monitoring and collection of data etc., but does not specify who would carry out those functions, nor that they would all necessarily be carried out by one body.

157. Section 9(4) also makes provision for the publishing of an annual report about cases by any body or person to whom the regulations apply including the lessons to be learnt from them.

158. Much of the written evidence in particular, referred to the difficulty in assessing the redress arrangements because of a lack of information regarding the management of it. A number of witnesses recommended that there would need to be some sort of overseeing body to deal with guidance and ensure consistency while ensuring ownership of the process at a local level. It was suggested that this might lead to variances at the local level but that the importance of local ownership outweighed the risk of people interpreting things differently. There seemed to be general agreement that there was a need for consistency across Wales, particularly in relation to tariffs and standards of investigation.

159. The Welsh Risk Pool said that "local management led to better ownership, and that that led to lessons being better learnt."[124] They did, however, agree that it would be necessary for there to be central support for claims managers.

160. Blaenau Gwent LHB outlined further the importance of local ownership on learning lessons from adverse incidents. They explained that complaints

[124] RoP, paragraph [114], 25 October 2007

are an important part of the process of understanding how services are delivered and whether they meet the needs of patients. They aim to:

> "learn from complaints and concerns to enable us to continue to improve services, build on best practice and provide services that are of the highest standard and quality."[125]

161. The Minister told us she was not in favour of setting up an overseeing body, as they were doing in England and wanted to keep a local emphasis within the scheme. She said she could not make a judgement on how the scheme would work in practice until she had consulted with NHS Trusts. She accepted that guidance would be required to ensure consistency across Wales and agreed the need for local organisations to be audited to ensure that the guidance was applied.

162. We recommend that the regulations make provision for consistent management and guidance of the redress arrangements.

Complaints and appeals process (Section 10)

163. The Measure does not provide for any right of appeal where the patient disagrees with the decision that has been made in relation to an offer of redress. A complaint can however be made to the Public Services Ombudsman about the administration of the arrangements i.e. whether a decision was properly taken. The only avenue open to a patient who is unhappy about an offer made to them under redress arrangements would be to refuse the offer and pursue a claim through the courts as is the current position.

164. The LSC considered that the Measure ought to make provision for an appeal or review of any outcome and that any appeal decision should be made by an independent body. They acknowledged that the Speedy Resolution Scheme does not have an appeals process but argued that:

> "given the redress scheme is intended to be permanent, the amount of damages that may be at stake and the consequent impact on claimants' lives, for claimants to have confidence in it they should be able to challenge an outcome."[126]

165. We did not receive a great deal of evidence on this issue but we are conscious that any appeals process could make redress arrangements more complicated, undermining the objective of a speedier system. We also consider there is a danger that an appeals process might be seen as a way of challenging an award simply to gain a higher settlement. We consider that as patients who are unhappy with an award have the right to refuse the offer and follow the litigation process, coupled with the provision to make a

[125] Written evidence, NHSR14
[126] Written evidence, NHSR11

complaint about the process itself, there is sufficient protection for patients in this regard.

Powers to make regulations (Section 11)

Assembly procedures for regulations

166. As detailed earlier in this report, the Measure is framework in nature and gives power to Welsh Ministers to implement and set out the detail of redress arrangements in regulations. Section 9 of the Measure sets out the main elements of redress arrangements that can be made through regulations and Section 11 sets out the Assembly procedure that will apply to regulations made under the Measure.

167. As currently drafted only the first set of regulations made under the Measure would be subject to the affirmative procedure which means that they have to be approved by a vote of the Assembly in plenary (and cannot be amended). Subsequent regulations, other than those which amend Acts of Parliament or Assembly Measures, would be subject to the negative procedure in the Assembly. The negative procedure allows Welsh Ministers to make regulations without Assembly approval but the Assembly could, within 40 days, annul the regulations even if they have come into force. The affirmative procedure provides more opportunity for scrutiny by the Assembly before regulations come into force.

168. As outlined previously we have received evidence against so much of the detail being made by regulations but this section focuses on the appropriateness of the procedures for making regulations under the Measure.

169. We received evidence which expressed concern that only the first set of regulations would be subject to the affirmative procedure with subsequent exercise of powers subject to the negative procedure. This arrangement means that if the redress scheme were only initially rolled out in the secondary care sector as indicated by the Minister, regulations relating to a redress scheme for the primary care sector for example, would be made under the negative procedure and so, subject to less scrutiny by the Assembly. MPS and DPL commented on the fact that "There may be fundamental changes to the NHS Redress scheme at a later date and… it is our view that all regulations under the Measure should be scrutinised and debated in plenary."[127]

170. The Subordinate Legislation Committee considered the specific issue of regulation making powers, taking evidence from Cymru Yfory, The Law Society and the Minister for Health and Social Services and reported to the

[127] Written evidence, NHSR24

Assembly in November 2007.[128] They recommended that the level of scrutiny in relation to the regulations be as strong as possible.

171. In considering whether the procedures for regulations were appropriate the Subordinate Legislation Committee recommended that the first set of regulations should follow the "super-affirmative"[129] procedure and also set out specific recommendations in relation to procedures for subsequent regulations which, if accepted by the Minister, would mean that a greater degree of scrutiny would be carried out in relation to all regulations other than those of a technical or updating nature. These recommendations are outlined in Annex D.

172. The Minister has already indicated both to this Committee and to the Subordinate Legislation Committee[130] that she will bring forward amendments at Stage 2 to ensure regulations made under Section 1(5) of the Measure, which refers to Welsh Ministers' powers to specify the qualifying services and Section 3, which makes provision for accessing redress, would be made subject to the affirmative procedure in all cases.

173. We welcome the Minister's commitment to bring forward amendments at Stage 2 to tighten up the procedures for regulations made under the Measure and support the specific proposals outlined by the Subordinate Legislation Committee for a greater number of regulations to be subject to the affirmative procedure.

Duty to consult on regulations

174. The Measure does not contain any specific duty to consult on the proposed regulations so even those regulations subject to the affirmative procedure would have limited scrutiny and engagement outside the Assembly. Even those organisations which supported much of the detail of a redress scheme being made through regulations supported the need for full engagement with stakeholders and wide consultation.

175. We received much evidence in support of a statutory duty to consult. AvMA stated that "although the Welsh Assembly Government has a good track record in consulting and involving stakeholders… we believe it would be appropriate that the Measure put a duty on Ministers to consult on draft regulations."[131]

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[128] Subordinate Legislation Committee report, Report on the NHS Redress (Wales) Measure 2007, which is available at: http://www.assemblywales.org/slc_3_-10-07_report_on_nhs_redress_measure_e.pdf

[129] The precise detail of a super-affirmative provision can vary, but broadly involves imposing a requirement on a Minister to lay draft regulations before the legislature typically for a period of 60 days and to be required to take into consideration representations made by the legislature prior to them being laid for approval.

[130] Annex C to the Subordinate Legislation Committee report, Report on the NHS Redress (Wales) Measure 2007

[131] Written evidence, NHSR19

176. The Minister argued that a statutory duty to consult on this Measure would be counterproductive and give the impression that in legislation where there was no such duty there would be no need to consult. She said that she would adhere to the Assembly Government's long established practice of consultation and carry out a full public consultation on any regulations before they were made. The Subordinate Legislation Committee accepted the Minister's assurances on this.

177. We are concerned that, as outlined in the Explanatory Memorandum,[132] there has been no previous consultation on these proposals other than in the Chief Medical Officer for England's report, *Making Amends,* which looked at reforming the way clinical negligence claims were handled.

178. We recognise the Minister's commitment to consultation and the recommendations made by the Subordinate Legislation Committee. However, the evidence we received strongly supports the need for a statutory duty to consult on regulations and we recommend that given the wide regulation making powers this Measure confers on Welsh Ministers there should be a statutory duty to consult on all regulations subject to the affirmative procedure.

[132] Explanatory Memorandum, paragraphs 4.1-4.2

7. FINANCIAL AND RESOURCE CONSIDERATIONS UNDER THE SCHEME

179. The Explanatory Memorandum states that, at the time the Measure was introduced, the financial costs were uncertain and formed part of the detail to be identified by the Putting Things Right project. The Memorandum does, however, refer to initial indications which put the cost impact somewhere between a potential saving of £750,000 and additional costs of £3 million a year. The Memorandum recognises that significant costs will be associated with the training and development of staff under the scheme and the provision of free legal advice and advocacy support for patients.

180. In accordance with Standing Order 14, the Finance Committee considered the financial information provided by the Minister in the Explanatory Memorandum. In its report,[133] the Committee stated that it did not consider the assessment of the Measure's financial impact to have been completed adequately and expressed disappointment that the Measure had been introduced without more detailed work.

181. They referred to the financial estimates that had been prepared by the Minister which were based on a number of assumptions made by the Department of Health in relation to the scheme proposed for England in the NHS Redress Act 2006. They were concerned that there were a number of factors that might cause the financial estimates to be inaccurate. Specifically, the Committee referred to the fact that the proposed scheme for Wales could apply to cases involving primary care and, as such, was broader than the English legislation. This difference in scope suggested the cost to Wales would be proportionately higher.

182. The Finance Committee noted that work to assess the financial impact of the Measure was currently underway and concluded that it could not reliably assess the impact of the Measure until that work had been further progressed. On this basis, the Committee recommended that the Stage 1 debate on the Measure not take place until they had been able to consider a more accurate estimate of the costs involved.

183. In oral evidence, the Chair of the Finance Committee accepted that with any new policy there will always be some uncertainty about the financial impact but said that "you cannot take the basis of your figures from different legislation in England. If that is the basis of the figures, they will quite obviously be wrong."[134]

184. We consider there to be a number of separate issues in relation to the financial impact, namely, the cost of providing advice and assistance, the cost of provision of medical experts, the cost of providing specialist training for staff, and whether or not the redress scheme will lead to an increase in the level of claims for compensation.

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[133] Finance Committee report, FIN(3)-07-R02: Report on NHS Redress (Wales) Measure 2007, which is available at: http://www.assemblywales.org/cr-ld6827-e.pdf
[134] RoP, paragraph [8], 6 November 2007

185. Citizens Advice Cymru suggested that the initial cost of legal fees would be considerable, but that as lessons are learned and fewer errors occur, the costs of the scheme would decrease over time.[135] MDU and DPL suggested that whilst there may be cost savings to the NHS in terms of legal and medical experts' costs, these would need to be offset against the likely increase in cases.[136]

186. Other evidence disputed whether there would be likely to be any cost savings at all. WHLS suggested that because independent expert and legal advice would be vital in satisfying claimants and clinicians of an outcome of an investigation, the cost of such input would be unlikely to fall.[137]

187. In response to the lack of clarity in the Explanatory Memorandum on the cost of legal advice under the scheme, the Legal Services Commission called for a full assessment to ascertain the financial impact of these proposals.[138]

188. Other evidence focused on the importance of conducting thorough investigations and the increased costs of training specialist staff across the NHS and we have commented on this particular issue elsewhere in the report.

189. Many witnesses commented on the likely increase in the number of cases seeking compensation and the impact that would have on the NHS budget. Citizens Advice Cymru considered that the number of cases would be likely to increase but contended that this would not necessarily be because more people were just "jumping on the bandwagon,"[139] but that it had been so difficult for some patients to go down the litigation route this had limited claims in the past. So they argued that simplifying the system in itself would lead to a higher level of cases.

190. The Minister initially told us that she would not be prepared to put figures on the likely costs of the scheme until the details had been determined. She did, however, suggest that current indications were that the new arrangements would not cost much more than the current system that is in place. She also stated that she expected there to be an increase in the number of claims for redress under the proposed scheme. The Minister urged us to look at the possible costs of the scheme in the overall context of the NHS budget of £5 billion.[140]

191. We note the Finance Committee's recommendation that the Stage 1 debate should not take place before a more detailed assessment of the financial impact of the scheme has been provided by the Minister. We acknowledge the Finance Committee's concerns and recognise that it is

[135] RoP, paragraph [123], 2 October 2007
[136] Written evidence, NHSR24
[137] RoP, paragraph [139], 25 October 2007
[138] Written evidence, NHSR11
[139] RoP, paragraph [120], 2 October 2007
[140] RoP, paragraphs [129]–[134], 6 November 2007

important that any information which is laid in the Assembly accompanying a legislative proposal should be accurate and specific to Wales. We have received an assurance from the Minister that the necessary financial information will be provided for the Stage 1 debate.

8. CONCLUSION

192. The Committee welcomes this first proposed Assembly Measure and agrees unanimously to its general principles subject to the additional information set out in this report being presented by the Minister for the Stage 1 debate.

193. We recognise that the process taken for this first proposed Measure is not necessarily one that will set a precedent for future Measures. The proposed Measure is a product of the NHS Redress Act 2006 and, as such, much of the policy was still being developed while we were conducting our scrutiny work. This made it more difficult for stakeholders to come to a view on some of the general principles.

194. We are grateful to the Minister for the information provided by the Working Groups which has helped our consideration. We consider, however, that a substantial amount of detail still needs to be finalised before the regulations under the proposed Measure can be prepared.

195. We expect future Measures to be handled differently. We consider that the policy behind a legislative proposal must be finalised before a proposed Measure is introduced for consideration by the Assembly. This will allow a greater degree of engagement with external stakeholders in terms of whether the legislation meets the policy objectives. It will also allow the relevant legislative committee to undertake proper and detailed scrutiny of the proposals.

Annexes

Proposed NHS Redress (Wales) Measure Committee

Written evidence received

Reference	Name/ Organisation
NHSR1	Conwy County Borough Council
NHSR2	Social Service Directorate, Caerphilly County Borough Council
NHSR3	Citizens Advice Cymru
NHSR4	Community Pharmacy Wales
NHSR5	British Medical Association Wales
NHSR6	Optometry Wales
NHSR7	Vale of Glamorgan Local Health Board
NHSR8	Cymru Yfory – Tomorrow's Wales
NHSR9	Age Concern Cymru
NHSR10	Chartered Society of Physiotherapy in Wales
NHSR11	Legal Services Commission
NHSR12	Wales Council for Voluntary Action
NHSR13	All Wales Forum of Parents & Carers of People with Learning Disabilities
NHSR14	Blaenau Gwent Local Health Board
NHSR15	Bridgend County Borough Council
NHSR16	David Smith
NHSR17	National Pharmacy Association
NHSR18	Royal Pharmaceutical Society of Great Britain
NHSR19	Action Against Medical Accidents
NHSR20	Wales Board of Community Health Councils
NHSR21	Carmarthenshire County Borough Council
NHSR22	Hafal
NHSR23	Medical Defence Union
NHSR24	Medical Protection Society and Dental Protection Limited (joint submission)
NHSR25	Royal College of Physicians
NHSR26	Tim Musgrave
NHSR27	Royal College of Nursing Wales
NHSR28	British Dental Association Cymru
NHSR29	NHS Centre for Equality and Human Rights
NHSR30	Bro Morgannwg NHS Trust
NHSR31	The Law Society
NHSR32	Welsh Health Legal Services
NHSR33	Welsh Risk Pool
NHSR34	Welsh NHS Confederation

Proposed NHS Redress (Wales) Measure Committee

Schedule of oral evidence

Date	Witnesses
2 October 2007	**Wales Board of Community Health Councils (CHCs)** • Peter Johns, Director, Board of CHCs in Wales • Catherine O'Sullivan, Chief Officer, Gwent Community Health Council **Citizens Advice Cymru** • Alun Gruffudd, Public Affairs Officer • Angela Williams, Information Officer for Wales • Saz Willey, Vale of Glamorgan CAB
11 October 2007	**Bro Morgannwg NHS Trust** • Dawn Davies, Head of Governance Support unit • Caroline Whitney, Professional Lead for Claims **Medical Protection Society (MPS) & Dental Protection Limited (DPL)** • Dr Stephanie Bown, Director of Education and Communications • Raj Rattan, Dento-Legal Adviser, Dental Protection Limited **British Medical Association (BMA) Cymru** • Dr Tony Calland, Chair, BMA Wales
16 October 2007	**Royal College of Nursing (RCN) Wales** • Tina Donnelly, Director • Chris Cox, Assistant Director of Legal Services **The Law Society** • Kay Powell, Solicitor and Policy Adviser • Tessa Shellens, Morgan Cole Solicitors • Mari Rosser, Hugh James Solicitors

Date	Witnesses
25 October 2007	**Medical Defence Union (MDU)** • Dr Christine Tomkins, Deputy Chief Executive and Head of Professional Services • Dr Matthew Lee, Deputy Professional Services Director **Action Against Medical Accidents (AvMA)** • Peter Walsh, Chief Executive • Hugh Williams, Deputy CEO **Welsh Health Legal Services (WHLS)** • Anne-Louise Ferguson, Managing Solicitor **Welsh Risk Pool** • John Bowles, Manager **Welsh NHS Confederation** • Mike Ponton, Director
6 November 2007	**Finance Committee** • Alun Cairns AM **Subordinate Legislation Committee** • Dai Lloyd AM **Minister for Health and Social Services** • Edwina Hart AM • Pat Vernon, Head of Public and Patient Involvement, Department for Health and Social Services

Y Pwyllgor ar y Mesur Arfaethedig ynghylch Gwneud Iawn am Gamweddau'r GIG (Cymru) 2007

Proposed NHS Redress (Wales) Measure 2007 Committee

Cynulliad Cenedlaethol Cymru
National Assembly for Wales
Bae Caerdydd / Cardiff Bay
Caerdydd / Cardiff CF99 1NA

4 October 2007

Dear Edwina

Scrutiny of the Proposed NHS Redress (Wales) Measure 2007

At its meeting on 2 October 2007, the NHS Redress Measure Committee heard oral evidence on the proposed Measure at Stage 1 of the legislative process. At the meeting, Committee members raised concerns that there is a substantial amount of work still to be completed with regard to the detail of the policy of the proposed system of NHS redress.

The Committee understands from oral and written evidence that the Putting Things Right project has been tasked to develop the detail of various aspects of the NHS redress system. Also, in oral evidence to the Finance Committee on 20 September 2007, Government officials referred to a working group that has been established to look at the detail of a system of NHS redress. On the basis that this ongoing work is likely to inform to a significant extent any Regulations made under the Measure, the Committee is concerned that it has not been made aware of its detail to date.

The Committee would like to receive a detailed account of the work undertaken, either as part of the Putting Things Right project or any other working group that is involved in the policy development relating to the proposals outlined in the Measure. This account should also include information on any current or planned work in this area and the related timescales for completion.

In view of the deadline for the completion of the Committee's consideration of the Measure at Stage 1, the Committee would like to consider a paper at its meeting on 16 October 2007. To allow this, I would be grateful to receive the information by Friday 12 October.

Yours sincerely

Jonathan Morgan

Jonathan Morgan AM
Chair

Edwina Hart AM MBE
Y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Our ref: EH/06414/07
Your ref:

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

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Jonathan Morgan AM
Chair
NHS Redress Measure Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

10 October 2007

Dear Jonathan,

Thank you for your letter of 4th October.

I am very happy to share information with you about the Putting Things Right project.

As you know, I am committed to ensuring that as much of the detail as possible is put before Members as it develops. Three working groups are looking at how these processes could work in practice and I am attaching a background note, which sets out the groups, their membership and terms of reference. I have also sent this to Dr Dai Lloyd, Chair of the Subordinate Legislation Committee and I am enclosing a copy of my letter to him.

As you will see, the groups are being chaired, not by Welsh Assembly Government officials, but by stakeholders who are involved in this area of work as part of their day to day roles. The membership is similarly drawn. The groups are expected to make their interim recommendations in January. I therefore hope to be able to refer to the emerging findings in the debate on the Measure in Plenary on 22nd January, and that the Measure Committee will be able to consider them during its further consideration of the Measure in Stage Two.

I have also asked my officials to revisit the arrangements for the Advisory Group that we and the other party health leads agreed to set up to look at some of the issues outside of the pressures of the formal scrutiny of the Measure.

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

NHS WALES GIG CYMRU

PUTTING THINGS RIGHT

Project Progress Report

Update on Working Groups

Legal Advice Working Group

The group has been informed by the scoping work that has been undertaken around current small claim management arrangements in NHS Trusts in Wales and the way in which these arrangements are viewed by those who manage them and those who are affected by them.

Group Membership

Anne Louise Ferguson (chair)	Welsh Health Legal Services
David Rudd	Walker Smith and Way Solicitors
Yvonne Agnew	Leo Abse & Cohen Solicitors
Trish Gaskell	Welsh Risk Pool
Donna Few	Claims manager, North Glamorgan NHS Trust
To be confirmed	Finance
Kate Montague	Welsh Assembly Government

The terms of reference relate to their consideration and reporting responsibilities:

Issues to be addressed

- Options available to offer legal advice, free of charge to the patient
- Appropriate stages for provision of advice
- The level of skill necessary to provide such advice
- The need for and means by which such advice be seen as independent and trustworthy by all parties
- The need for such advice to be accessible
- Managing the need for the process to be acceptable to those providing the advice
- The cost implications for the provision of such advice
- Financial limits for compensation under the arrangements
- Appropriate reference for that limit e.g. total payment out, payment in respect of pain and suffering
- Potential tariff system for quantifying damages
- Status of documentation prepared during the process, i.e. disclosability etc
- Obtaining medical expert reports, including:
- Identifying experts
- Instructing experts

- Cost of obtaining reports
- Suspension of the limitation period, point at which the clock stops and starts running, time limits for accepting offers, etc

This list is not exhaustive and the group, on meeting, may identify other issues that need discussion and invite guests to provide further expertise if required.

The first meeting of the group was 2 October 2007. It is envisaged that the group will meet monthly and will provide an interim report to the Board by mid January 2008.

Investigations and Process Working Group

This group has been set up to review the investigation processes that are currently undertaken into complaints, claims and incidents by NHS Trusts in Wales and make recommendations; to consider the merit of developing a single point of entry to streamline investigations and to make recommendations to the Welsh Assembly on the way forward by May 2008.

Proposed Membership

Adam Peat (Chair)	Public Services Ombudsman for Wales
Dawn Davies	Head of Governance Support Unit, Bro Morgannwg NHS Trust
Julie Parry	Patient Safety Manager North Wales, NPSA
Hazel Abbott	Risk Manager, Swansea NHS Trust
Sue Gregory	Nurse Director, Cardiff & Vale NHS Trust
Lynne Ryan	Head of Regulation, Health Inspectorate Wales
Gren Kershaw	Chief Executive, Conwy & Denbighshire NHS Trust
Pat Vernon	Head of PPI Branch, Welsh Assembly
Piera Cassettari	Project Manager, Welsh Assembly
Stephen Hunter	Medical Director, Gwent Healthcare NHS Trust
Cathy O'Sullivan	Chief Officer, Gwent Community Health Council

Issues to be addressed:

The group will consider the current processes separately and will then consider an overall approach:

<u>Complaints Management</u>

- Review the results of the questionnaires sent to NHS Trust Complaints Managers, CHC Advocates and Complainants over the summer which sought views on how effective Local Resolution and Independent Review are currently and suggested improvements.
- Determine what, if any, further scoping work needs to be carried out in this area to build a full picture of how complaints are currently investigated.
- Consider scope for improvement to current Local Resolution procedures within the NHS complaints process and make recommendations
- Consider whether the independent stage of the NHS complaints process continues to have a role and make recommendations.

Claims Management

- Review the results of questionnaires sent to NHS Trust Claims Managers on the effectiveness of the claims investigation process.
- Determine what, if any, further scoping work needs to be carried out in this area to build a fuller picture of how complaints are currently investigated.
- Consider scope for improvement to current claims management procedures and make recommendations.

Incident Management

- Review the results of the questionnaire sent to NHS Trust Risk Managers on incident management.
- Determine what, if any, further scoping work needs to be carried out in this area.
- Advise on whether and how incident management could be included in any new arrangements.
- Consider scope for improvement to current incident management procedures and make recommendations.

Overall

- Consider whether a single initial investigation process should be developed. If so:
- Explore the detail of such an investigation process.
- Look at examples of good practice across all investigations to determine if they can be shared.
- Consider how recommendations for improvement and change to existing processes can be incorporated.
- Agree what advice, guidance and support would need to be available to NHS Trusts to ensure that they act appropriately when things go wrong, including:
  - What new arrangements would broadly look like
  - Provision for vulnerable groups
  - Appeals
  - Links to other processes (e.g. HIW, CSSIW)
  - Cross border issues
  - monitoring and data collection
  - potential barriers to such developments

Determine how the NHS Redress arrangements for low value clinical negligence claims could be incorporated into the investigation process.

- Consider if separate guidance is needed for primary care.
- Consider and make recommendations on skills and training needs.
- Contribute to the financial assessment of any potential new arrangements.
- Make full recommendations to the Welsh Assembly.
- Advise and assist the Assembly in the development and issue of subsequent guidance and training.

Meetings of the group have been arranged for 17 October, 21 November and 12 December 2007.

The group will undertake to provide an interim report to the Board by mid January 2008 on the current position and proposed way forward and final recommendations by 30th May 2008.

Advocacy and Assistance Working Group

It has been decided that the working group looking at support and assistance for individuals seeking redress will be been convened slightly later than the two other groups. This was felt sensible to allow work undertaken in the other working groups to inform the group in their considerations.

Proposed Group Membership

Cathy O'Sullivan (Chair)	Gwent CHC
Hugh Williams	AvMA
Kate Montague	Welsh Assembly Government
TBC	NHS Trust Patient Experience Manager
TBC	Patient Representative
TBC	Independent Complaints Facilitator
TBC	Age Concern
TBC	Citizen's Advice Cymru

Terms of Reference

- The group will consider the issues outlined below with reference to the Measure and the wider project "Putting Things Right"
- The group will be responsible for reporting recommendations back to the Project Board of Putting Things Right
- Communication between members will be in the form of group meetings and e-mail communication
- There will be provision to invite individuals in to provide advice on specific issues
- The group will undertake the work within six months of commencement
- WAG will provide administrative support to the group.

Issues to be addressed

- Consider and make recommendations about the extent of the support and assistance to be provided.
- Consider and make recommendations about the extent of the support and assistance to be provided.
- Consider the options for providing such support and assistance and make recommendations about the most suitable
- Consider the cost implication of such recommendations
- Consider the need for such support to be accessible to all
- Consider through the potential impact which the provision of free legal advice would have on this issue.

The group will meet on 26 November and 17 December 2007. Its next meeting will be on 17 January 2008.

SUBORDINATE LEGISLATION COMMITTEE

PROPOSED NHS REDRESS MEASURE – POWERS FOR THE WELSH MINISTERS TO MAKE DELEGATED LEGISLATION

As published in the Subordinate Legislation Committee's Report on the Measure, at Annex G

(1) Section conferring power	(2) Section setting out kind of provision to be made	(3) Description of provision to be made by the power	(4) Assembly Procedure (Proposed Measure as laid)	(5) Assembly Procedure (Minister's offer) -if different from column (4)	(6) **Assembly Procedure- Recommended by Committee**
1(1)	1(4)(b)	Specifying bodies or persons (in addition to health care professionals) for whose acts or omissions redress may be provided under the scheme.	Affirmative (first regulations) then negative		Affirmative (all regulations)
1(1)	1(5)	Specifying what services are "qualifying services".	Affirmative (first regulations) then negative	Affirmative (all regulations)	Affirmative (all regulations)
1(1)	2	Redress under the regulations including the assessment of and limits on compensation and the provision of other remedies.	Affirmative (first regulations) then negative		Affirmative (first regulations) then negative
1(1)	3	Accessing redress, including who may claim, how to claim, time limits for claiming and circumstances in which no claims may not be made	Affirmative (first regulations) then negative	Affirmative (all regulations)	Affirmative (all regulations)

1(1)	4	Imposing duties on those investigating or reviewing cases to consider if redress may be available and if so to take specified action	Affirmative (first regulations) then negative		Affirmative (first regulations) then negative
1(1)	5	Providing how redress is to be delivered, including how and by whom investigations are to be carried out, how settlement offers are to be made and considered, provision of reports of investigations and the exclusion of recourse to the courts when an offer is accepted.	Affirmative (first regulations) then negative		Affirmative (all regulations)
1(1)	6	Enabling the statutory time limits for bringing claims in the courts to be suspended whilst an application for redress under the scheme is being considered.	Affirmative (first regulations) then negative		Affirmative (first regulations) then negative
1(1)	7	Means by which free legal and expert advice is provided to those seeking redress	Affirmative (first regulations) then negative		Affirmative (first regulations) then negative.
1(1)	9	Enabling duties in relation to the operation of the redress scheme to be imposed on specified persons or bodies within the Health Service in Wales.	Affirmative (first regulations) then negative		Affirmative (first regulations) then negative
12(1)	12	Supplementary, incidental, consequential, transitional or saving provision, including modifications to Acts of Parliament and Measures passed before (or in the same year as) this Measure	Affirmative if regulations modify an Act of Parliament or an Assembly Measure, otherwise negative		Negative, unless contra- indicated by the content of the regulations

14(3)	14	Power to bring the Measure into force by Commencement Order.	None	None - **Note:** The Committee recommends that the Measure should not be commenced until the regulations are available for scrutiny

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PUTTING THINGS RIGHT
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Investigation and Process Working Group

Interim Report
December 2007

Background

The Investigation and Process Working Group has been set up as part of the Welsh Assembly's Putting Things Right Project. Its overall remit is to:

- review the current processes and procedures that are used by NHS Trusts in Wales when investigating complaints, claims and patient safety incidents
- reach a view on how well these processes are working
- consider ways in which the investigation processes could be strengthened and the scope for bringing the separate processes together, and
- consider what further guidance and training is needed within organisations to help them strengthen their investigation processes.

It will also consider how the proposal under the draft NHS Redress (Wales) Measure 2007, which will enable and empower NHS Trusts to secure redress in cases where clinical negligence has been determined without requiring patients to initiate formal legal proceedings, can be integrated into the investigation process.

The Terms of Reference and membership of the group are attached at Appendix 1.[141]

Purpose

This interim report informs the Putting Things Right Project Board of the work undertaken by the Working Group to date and the issues that it will be addressing before presenting final recommendations to the Project Board in May 2008.

The Minister for Health and Social Services has requested sight of interim reports before the next Project Board meeting so that key issues can be shared with the Proposed NHS Redress (Wales) Measure 2007 Committee ahead of their final Stage 1 Report on 25 January 2008.

Work undertaken so far

The Group has to date:

- Agreed the Terms of Reference
- Had three meetings

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- Considered whether a single investigative process which builds on best practice from the areas of complaints, claims and patient safety incidents should be developed.
- Considered the effectiveness of the current system of complaints handling by the NHS in Wales -
- Formulated proposals for improvements in complaints handling in which all issues will be dealt with consistently – although implementation arrangements in the primary healthcare sector will require further consideration

Prior to the Group meeting, stakeholders were consulted about the systems and processes currently being used. For example:

A questionnaire was sent to complaints, claims and risk managers in NHS Trusts to seek their view on the procedures they currently operate
A questionnaire was sent to all patients who requested and received an independent review in 2006/07 to ask them about their experiences of the process
A questionnaire was sent to independent review lay members to ask them how effective they believe the process to be.

Interim Conclusions and Recommendations

A Single Investigation Process

There is a need for investigation when something has gone wrong with patient care or patients have been put at risk. The need for investigation may become apparent through:

A report of a patient safety incident
A complaint by or on behalf of a patient
A clinical negligence claim

There are currently a small number of NHS Trusts in Wales which have, or are working towards, integrated processes, staff and departments dealing with risk management, incidents, complaints and claims. However, the majority currently have separate processes and departments for dealing with these matters.

The Group is clear that:

- Investigation processes for complaints, claims, and patient safety incidents can and should be aligned, with the basic approach to the investigation being to ‘do it once, do it early and do it well’. Undertaking one investigation, which can fully and appropriately deal with all of the issues raised, rather than multiple investigations under different procedures, should ensure that neither patients nor staff have to endure protracted, sometime multiple and open-ended investigations. The single investigation approach should to resolution of issues at the earliest possible point but could lead to a number of pathways to providing remedy, when this is appropriate.

- NHS bodies would need to reflect this approach within their structures and lines of accountability.

- Conducting investigations of this nature will require NHS bodies to ensure adequate resourcing with staff who possess the necessary skills, expertise

and competence. These staff must also be of an appropriate level of seniority or be able to easily access senior support.

- A common culture needs to be developed towards investigation, with NHS bodies genuinely displaying commitment to:
  - safety and quality
  - learning and improvement
  - being open, honest and fair. To make this a reality staff must feel empowered to report patient safety incidents at the earliest stage
  - ensuring the views and comments of staff directly involved in an event are gathered as part of the process but that management of the investigation and clinical opinion is independent of those involved staff, to ensure credibility
  - promotion of the approach at Board level.

- If things have gone wrong, NHS bodies should be honest and focus on what is a fair outcome for the patient/family in the circumstances. Where it is fair and appropriate, NHS bodies should feel able to make an offer of redress whether or not a patient has made a formal claim.

- If there is apparent liability in tort, complainants would have a choice, following initial investigation, of the NHS Redress route which is managed by the NHS itself; the Speedy Resolution Scheme (if it continues – subject to evaluation) which is a quicker version of the normal litigation process; or to take the traditional litigation route.

The current NHS Complaints Procedure

The group examined the current NHS complaints procedure in Wales, which is laid down by the National Assembly by statutory instrument and in guidance – Complaints in the NHS: A Guide to handling complaints in Wales. The procedure has two stages: Local Resolution (where the body complained against attempts to answer the complaint) followed if unsuccessful by Independent Review. There is consensus within the Group that the procedure works much better on paper than in practice. There are significant problems which require to be addressed both at Local Resolution and at Independent Review stage. Overall, the complaints process can be cumbersome, protracted and frustrating, not only for patients and their families, but also for the NHS staff involved. It can fail to recognise that making appropriate amends for maladministration or service failure may require financial redress in some cases which do not amount to a breach of a duty of care for which there is a strict legal liability. The complaints process can also be wasteful of NHS resources.

Defining a complaint

In the Group's view, the Assembly's guidance is unrealistic in that it rightly adopts a broad definition of what constitutes a complaint but then fails to recognise that many complaints meeting that broad definition can and should be dealt with informally by frontline staff. This leads in practice to different Trusts reaching different decisions as to what is a formal complaint to be dealt with under the NHS complaints procedure and what should be dealt with informally. The Group recommends:

1. The Assembly's guidance should require all NHS bodies to adopt the same definition of what a complaint is, namely "an expression of concern about NHS treatment or services, whether oral or written".

2. The guidance should explicitly recognise that very many complaints meeting that broad definition should be dealt with informally in the first instance by nurses, clinicians, and other frontline staff.

3. The guidance should lay down the following circumstances in which a complaint must be treated as a formal complaint under the NHS complaints procedure:
    - The complaint is made in writing
    - The complaint is made orally but the complainant asks for it to be dealt with formally
    - The complaint is made orally but is too serious in nature to be dealt with informally, provided that the complainant agrees this.

Timescales for the handling of cases locally

The Assembly guidance is also unrealistic in our view in that NHS bodies are required at Local Resolution stage in all cases to investigate the concerns raised and respond within 20 days. One size does not fit all, and it may simply not be possible to respond definitively to a complex complaint involving clinical issues (and in a hospital context, often involving a number of different members of staff) within that timescale. This too often results in purely nominal compliance, whereby a Trust Chief Executive signs a superficial response within the 20 day target period. When this fails to resolve the issue, Local Resolution may then drift in the absence of any further time pressure in the system. Members of the Group were aware of instances where Local Resolution had dragged on for many months, indeed sometimes years.

The Group recommends that any new arrangements should provide for the following timescales for the handling of cases locally:

2 working days (as now)

to acknowledge that the complainant has raised a concern which will be treated as a formal complaint.

25 working days

to provide either a definitive or a substantial interim response to issues raised. In straightforward cases this would be a definitive response representing so far as the Trust is concerned the conclusion of the local investigation. All complainants would have the right to appeal to the Ombudsman at the conclusion of an investigation.

In more complex cases, an interim response would give an update of progress so far in investigating the complaint and an outline of what the complainant could expect and by when. This might include options such as the offer of a meeting with Trust staff or of mediation.

It would be expected that when an investigation extended beyond 25 days, all parties involved would be updated at regular intervals of 25 working days, even if there were nothing to substantive to report, until the investigation and response was completed.

More work will need to be done to define what can generally be considered a ‘complex’ complaint because there needs to be a balance between the need for time extension for complex cases with timescales that are suitably ambitious to ensure NHS bodies are making every effort to resolve non-complex matters within 25 days.

6 months

Investigation and report should be within 6 months in all cases and the Ombudsman would accept a complaint for consideration if the Local Resolution had not been carried out within this timescale. However, there must be recognition that any issues of liability and, where appropriate, quantifying financial redress may, justifiably, take longer to conclude and there would need to be some recognition of this within procedures and timescales.

12 months

The group discussed the possibility of having an overall time limit of 12 months for cases that proceed under the NHS Redress route (whether or not they originally presented as a complaint rather than a claim). However, whilst it was agreed that this might be a useful working assumption, the group felt that more work needed to be done, in conjunction with the Legal Advice group, to determine a realistic overall timescale for this element of the process.

Redress

The Group recommends that guidance on the NHS complaints system should make it explicitly clear that proportionate financial redress for hardship suffered through maladministration or service failure can and should be offered in appropriate cases. It should not be necessary for the complainant to go to the Ombudsman before such redress is offered (with all of the overhead costs to the NHS which the process of an Ombudsman investigation entails).

Independent Review

At the conclusion of Local Resolution, a complainant who is dissatisfied with the outcome presently has one of two options: they may take their complaint directly to the Ombudsman; or they can request Independent Review (with the right to go to the Ombudsman thereafter if still dissatisfied). NHS bodies are obliged to transmit requests for independent review promptly to the All-Wales Independent Review Secretariat. The Secretariat will arrange for the request to be considered by a Lay Reviewer, who may commission clinical advice. The lay Reviewer may reject the request if s/he considers that the response to the complaint under Local Resolution was adequate; may refer the complaint back to the body for a further attempt at resolving the complaint locally; or may arrange for the complaint to be considered by an Independent Panel.

Feedback from complainants who have been to Independent Review is poor. In particular the “snakes and ladders” aspect of being referred back for a further attempt at Local Resolution is often bitterly frustrating for complainants (and for NHS staff too). Such reference back often leads to further long delay and to complaints to the Ombudsman, with the complainant now complaining about the operation of independent Review as well as the issue originally complained of. In the view of the Group, the right approach to Local Resolution is "do it once, do it well." Reference back by a lay reviewer runs directly counter to that philosophy.

In Scotland, the independent review stage has been abolished. Complainants still dissatisfied after Local Resolution go direct to the Scottish Ombudsman in all cases. This streamlined system appears to be working well. The Scottish Ombudsman has needed some additional staff to meet the increased workload but this has been more than offset by savings to the NHS.

The Group recommends that one of the following options be adopted:

- the Scottish model or, failing that
- a fundamentally redesigned streamlined Independent Review, under which, for example, a lay reviewer who believes that Local Resolution was unsatisfactory has only the options of convening a Panel or of referring their analysis and the complaint to the Ombudsman.

If a version of Independent Review were to be retained, it could only be, as now, as an optional stage which complainants could resort to if they wished: the right for complainants to have their complaint considered by the Ombudsman immediately following Local Resolution has a statutory basis in the PSOW Act.

Application to primary care

The Group's main focus to date has been on NHS Trusts, and it has to be said that the Group's current membership does not include representation from the primary care sector. The Group's view is that the NHS complaints process should remain as now, one which applies to the primary sector as well as to secondary care. It should be borne in mind that a patient's need to complain about their treatment by the NHS in Wales may often span the primary and secondary health sectors.

In the Group's provisional view, while it is wholly appropriate for primary care practitioners to deal themselves with the very many complaints which can be dealt with informally, it will not often be possible for e.g. a GP surgery to credibly investigate a complaint against a GP. The Group suggests that responsibility for investigation of formal complaints may need to rest with LHBs as commissioners of care, and that further developing and strengthening an investigative capacity which is variable at present within LHBs, may be a suitable area for inter-LHB co-operation.

The extension of the NHS Redress element of any new investigative arrangements into primary care will require additional work with input from LHBs and primary care practitioners. The different indemnity arrangements, the mix of NHS and privately provided care as well as the business-focussed provision of services across the primary care sector will have to be carefully considered before this element can be progressed further.

Next Steps

Before the final report, the Group will look in further detail at:

- The current processes and practices used in patient safety incident reporting and claims management
- Further development of, and recommendations for, a single investigative process
- The process for offering redress, including timescales, in conjunction with the Legal Processes Working Group
- Staff resources, skills and training needed to ensure that a single investigation process works well
- What guidance needs to be developed to implement the new arrangements

The Group would also look further at options for retaining a version of Independent Review should the Minister wish it to do so.

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PUTTING THINGS RIGHT
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Legal Advice Group

Interim Report
December 2007

Background

The Legal Advice Working Group has been set up as part of the Welsh Assembly's Putting Things Right Project and its overall remit is to;

- Advise on the most appropriate provision of independent legal advice that is without charge to the patients
- Advise on the most appropriate stages for the provision of such advice.
- Advise regarding financial limits within which new arrangements would operate.

The Terms of Reference and membership of the group is attached at Appendix 1.[142]

Purpose

This interim report seeks to update the Putting Things Right Project Board on the work undertaken by the Working Group to date and the issues that it will be addressing prior to presenting final recommendations to the Board in May 2008.

Prior to that it will be shared with the Minister for Health and Social Services, who has requested sight of the report before the next Project Board meeting so that key issues can be shared with the Proposed NHS Redress (Wales) Measure 2007 Committee prior to producing their final Stage 1 Report on 25 January 2008.

Work undertaken so far

The Group has considered the following issues /questions

Why is Legal advice necessary?

- Legal advice is necessary as it will provide the patients and NHS Trusts with;
  - Independent advice
  - Quality assurance regarding the investigation
  - Quality assurance regarding the proposed settlement

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- It was agreed that advocacy as proposed by the Community Health Councils, was not a substitute for specialist legal advice, it was envisaged that there would be situations where both parties are involved in assisting the patient. The patient should not be precluded from using one where the other is involved.

Who should provide such advice?

- The group reviewed the current legal providers of legal advice to include Citizens Advice Bureaux, Specialist clinical negligence solicitors (those who are recognised members of either AvMA or Law Society Clinical Negligence panel), Non specialist solicitors, legal executives and members of the Civil Bar.

  The use of Barristers to consider the information collated during the investigation may not be appropriate as there are few specialist clinical negligence Barristers in Wales; furthermore, it is not usual in their practice to engage in direct correspondence with parties or witnesses.

  It was not considered appropriate to use the Citizens Advice Bureaux for legal advice, as there is no certainty of expertise within the organisation.

  It was concluded that specialists were the most appropriate in order to ensure consistency and quality assurance of advice provided.

  While there was no agreement that it was necessary, it was generally felt to be preferable for the solicitors to work within firms based in Wales. If firms outside were offering such advice they would need to travel to the client in order to make the advice appropriately accessible.

- It was concluded that such advice would allow for;
  - Analysis and understanding of the legal issues and tests, which are preserved within the NHS Redress Measure
  - Knowledge of relevant issues and of quantification of damages and future liabilities
  - Avoidance of future litigation in many cases and recognition of when formal proceedings would be more appropriate
  - Avoidance of under settlement of a patient's claim
  - Consideration of the financial implications of long-term clinical sequelae on the patient's future.

Points at which legal advice should be provided

It is recommended that legal advice should be made available to the patient at the following stages

1. At conclusion of investigation undertaken by Trust at which point;
   a) Liability may be admitted by the Trust and an offer of redress made. (NB this may include other elements such as rehabilitation or early readmission to hospital, as well as financial compensation.)
   b) Liability may be denied by the Trust and no offer is made
2. Further to breach of duty being admitted but causation and or condition and prognosis of the patient needs further expert opinion through the instruction of a further medical expert. Such further instruction will be undertaken jointly

between the Trust and the patients' legal adviser. This in itself may lead to the Trust choosing to make an offer of settlement or not.

3. Further to 2 and in the circumstances of the Trust offering to make an ex gratia offer without making any admissions of liability, where financial offer and or package of care is made.
4. Any point at which an offer of settlement is made.

(NB These are the points at which the group considered that legal advice should be offered It was recognised that higher levels of legal advice would be necessary or preferable to some claimants although it was recognised that some claimants would prefer either not to involve a solicitor at all, or to have legal assistance at one or all of the stages. It would be the patients' choice when and if such advice were accessed.)

The cost of such advice

As the working group were of the consensus that legal advice should be provided by specialist clinical negligence solicitors, the views of this group were canvassed through a meeting and a questionnaire. It was agreed for the protection of the public specialist solicitors should be used for such advice and to achieve this the remuneration has to be profitable whilst still being proportionate.

Further to discussion, the Claimant solicitor members of the working group presented four options discussed with their colleagues to the Legal Advice working group:

1. <u>Fixed fee for supporting the patient through the whole process</u>

This involved one single fee, two situations were identified,

a) Uncontested matters i.e. where the Trust conceded liability for any damage caused and were anxious to make a settlement offer of whatever nature. The fixed fee here was £3,500

b) The second higher fee covered situations where the NHS Trust felt they had no legal liability for any damage caused but following consultation, the patient and their legal adviser did not agree, necessitating further investigation, evidence collation and analysis. The fixed fee here was £5,000

2. <u>Fixed fee for various stages</u>

This option allows for the provision of advice on a fixed fee rate for various stages; the following were suggested as being appropriate

a) Where admission of liability or an ex gratia offer to compensate is made, consideration of the investigation provided by the Trust would attract a fee of £1,500 plus VAT.

b) Where there is no admission but there is an agreement to jointly instruct experts on breach of duty of care and causation a further fee of £1,500 plus VAT would be incurred, together with additional sums for each additional expert instructed.

Review of expert reports and advice on quantification would attract a fixed fee of a similar amount.

There would, however, need to be recognition that some cases are more complicated and require further legal input which may attract either a further fixed fee or hourly rates

3. Hourly rate for work undertaken

The hourly rate was agreed at £175 per hour. The hourly charge out rate for panel members is £195 +vat in Cardiff. The hourly rate agreed for the Speedy Resolution Scheme 2 years ago was £150; the rate agreed was therefore a compromise between the two.

It was not agreed how this method of funding should be controlled, e.g. by capping the costs or the hours of work undertaken. This option would require scrutiny of the legal fees submitted and would require some form of arbitration if no agreement could be reached.

4. Composite costs

A minority amongst the solicitors group favoured an approach whereby costs would be charged on a simple hourly rate basis for work carried out immediately following the investigation. At this point the solicitor would consider the outcome of the investigation and advise the patient as to the appropriate way forward. The hourly rate would be £175+VAT but capped at a total of £1500. Thus in a simple low value case the work done might only involve 1 or 2 hours. In more complex case with greater levels of documentation it could be up to 8 -9 hours of work. If the case is then concluded no further costs would be incurred or be payable.

Should the matter not conclude at that point then a set fixed fee of £1500 would be payable for an investigation into liability issues and/or a fixed fee of £1500 for investigating the value of the claim.

The total cost for solicitor's fees under this option would be a maximum of £4500 but might be as low as £175.

Financial Limits

Consideration was given to the financial range of damages that could be covered by the arrangements, whether it was appropriate to limit the scheme to a top value and what effect limiting the value was likely to have. One important factor within the consideration process is the fact that these arrangements are likely to allow only for the instruction of joint experts rather than single experts as in traditional litigation.

There was a suggestion by the Legal Group that the amount for the total financial settlement (as per Clause 2(6)(a) should amount to no more than £20,000 where there is a liability dispute. Where the value of a claim may exceed this amount and liability remains in dispute, there may be a need for more rigorous investigation and instruction of independent separate experts. Other reasons for a low upper limit of damages are complexity of the clinical issues or legal difficulties in establishing causation.

However, it was recognised that all claims (or potential claims) would be initially investigated in the same thorough manner and if satisfied with the outcome of the investigation there should be no bar to a claimant and the Trust attempting to settle any claim, of any value without recourse to the judicial process.

This is an area of work where further work by the group is needed to consider the full range of options.

Further areas of general discussion

- Manner in which damages would be assessed - a tariff system would be helpful and provide guidance to the Trusts and consistency across Wales. The Judicial Studies Board (JSB) Guidelines provide a tariff for injuries, which is widely used and accepted. It is collated and updated regularly using court cases as precedent. It may be appropriate to compile a companion tariff for lower value cases which was acceptable to the specialist legal advisors, AvMA and the Law Society. This is an area where further work is necessary.

- Early intervention by the Trust involved - it was felt to be very important for the Trust to intervene as soon as possible after an adverse outcome to the patient to offer rehabilitative treatment and services. This not only serves to meet the needs of the patient as soon as possible, but also may mitigate any future physical or mental damage to the patient by providing early and effective treatment. It would also limit future financial liability for damages

- The Use of mediation/facilitation – this was seen as a very useful tool to be considered at various stages of the redress pathway to achieve an outcome acceptable to both patient and NHS body. There are a number of trained mediators within service providers across Wales who currently are under utilised. This is an area that is being considered in detail by the Advocacy working group. Liaison between the groups will take place to ensure that all aspects are considered.

- The Instruction of medical experts - Discussion took place surrounding the need for a national register of medical experts willing to provide opinion where expert medical advice is deemed necessary. Current problems in the existing system include;

    - Length of time taken to provide reports due to the need to prioritise existing clinical responsibilities
    - Over reliance on the good will of internal experts employed by NHS Trusts.
    - Difficulty in recruiting a wide enough range of experts at an acceptable level of expertise at a cost effective level of fees

- The place of the Speedy Resolution Scheme in any new arrangements - the scheme is currently being evaluated and it is hoped that the report will be available in May 2008

Next Steps

Before the final report the group will further consider:

- Cost and means of accessing legal advice
- Cost and register of medical experts
- Review all tariff systems including the JSB recommendations for low value cases, presently not adequately covered
- Conclude discussions on financial limits
- Time limits to be applied within arrangements

- The place of speedy resolution within arrangements
- Mediation and its role within the process
- Relationship between Advocacy and Assistance and Legal advice.

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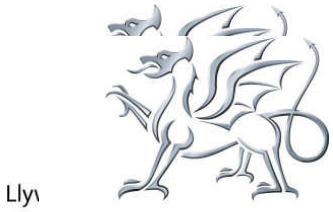

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PUTTING THINGS RIGHT
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Advocacy and Assistance Working Group

Interim Report
December 2007

Background

The Advocacy and Assistance Working Group has been set up as part of the Welsh Assembly's Putting Things Right Project. Its overall remit is to:

- facilitate access to appropriate support and advocacy for individuals who need advice and support about any aspect of NHS treatment or care, including making a complaint;
- ensure that the current areas of good practice in Wales are both maximised and consolidated;
- ensure that any recommendations made, work in conjunction with recommendations made by the other working groups; and
- seek to provide that any recommendations made work to support the undertakings given in the NHS Redress (Wales) Measure 2007.

A positive decision was made to commence the considerations of this group later than the other two working groups. This was to enable them to be informed as to the type of pathway that the patient would be undertaking, through which they would require support. Because of this, the recommendations in this report focus on improving advocacy and support within the current processes, particularly complaints. As the work on a single investigation process is developed by the Investigations and Process Working Group, providing advocacy and support throughout that process will be explored.

The Terms of Reference and membership of the group is attached at Appendix 1.[143]

Purpose

This interim report seeks to update the Putting Things Right Project Board on the work undertaken by the Working Group to date and the issues that it will be addressing prior to presenting final recommendations to the Board in May 2008.

Prior to that it will be shared with the Minister for Health and Social Services, who has requested sight of the report before the next Project Board meeting. Key issues can then be shared with the Proposed NHS Redress (Wales) Measure 2007 Committee prior to producing their final Stage 1 Report on 25 January 2008.

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Work undertaken so far

The Group has to date:

- identified services available from the different organisations;
- identified the pathway that the complainant may take;
- identified the stages at which advocacy and assistance may be required; and
- recognised that different levels of support will be appropriate in each individual case.

Stakeholder Views

To inform the working groups stakeholders were consulted to establish what systems and processes are currently being used and to gain their views on how effective they are. For example:

- a stakeholder meeting was held in November 2006;
- a questionnaire was sent to complaints, claims and risk managers in NHS Trusts to seek their view on the procedures they current operate; and
- a questionnaire was sent to all CHC Advocates representing patients through the process to seek their views on the process, their role in it and scope for development.

Interim Conclusions and Recommendations

It is important to emphasise that these are general recommendations that will improve the overall advocacy and support that is available in Wales at present. It is envisaged that each of these areas will be tailored to the overall process for investigation and redress once further detail has been received from the other working groups.

Mapping the needs of complainants through the complaints pathway

The group have mapped main areas of access and the journey through the current complaints process to identify good practice and any gaps or areas for development. This exercise has identified a number of services already available but more needs to be done to ensure consistency and joined up working across these services.

Access to Advice and Assistance

<u>Patient Support Services (PSS)</u>

It is of paramount importance to ensure that the patients' journey and experience with the NHS in Wales is as smooth as possible, by ensuring people have access to on-the-spot help to tackle concerns quickly and to steer people to an appropriate source of help and advice. Guidance already exists - WHC(2004)069 - which sets out the Welsh Assembly Government's requirements for the on-going development of PSS in Wales.

NHS organisations in Wales are required to build PSS into day-to-day delivery ensuring that there are systems in place to deal with concerns and difficulties quickly and efficiently including the provision of an effective gateway to refer patients towards specialist advice and support such as advocacy services. There are different models

of PSS delivery, and it is essential that patients and carers and staff are made aware of arrangements for dealing with queries and concerns.

The Welsh Assembly Government also provided funding to support the development of PSS in the NHS South East Region from 2005-07 and final reports were submitted in May 2007.

Recommendation 1

The Advocacy and Assistance Group recommends that NHS organisations are able to ensure that appropriate information and assistance is available whenever required. If assistance is available it could prevent issues escalating by ensuring patients' concerns are addressed at the earliest opportunity. Therefore the learning and good practice from current PSS models and elsewhere should be shared with a view to learning lessons to ensure that similar models are developed and delivered locally across Wales.

It is anticipated that further development of PSS is not about setting up a new service but about co-ordinating and developing what is already available. PSS should become integral to normal service delivery and be delivered on a health economy basis with mechanisms in place that can address patients' concerns in a seamless and timely manner.

Recommendation 2

Patients should also be able to receive relevant information regarding access to advocacy and support services that are external to, and independent of, the organisation at any time. In particular, patients may wish to access this early in the complaints process. The information that is available must be consistent across Wales.

Ensuring access to appropriate advocacy and assistance

There are a variety of services available offering advocacy and assistance services to patients. The skill and knowledge areas of the service providers varies, and it is important that each organisation is aware of and able to inform the patient about the most appropriate service for their needs. (The services are detailed within appendix 2.)

It is felt that the services provided are under-utilised by patients. This may be due to a lack of appropriate, accessible and joined up information about services that would be helpful to them. It is also thought that more could be done to improve the understanding between the service providers themselves regarding the services each of them can offer.

Recommendation 3

The communication, information and assistance provided to patients requires a joint memorandum of understanding (MOU) across voluntary and statutory organisations across Wales to enable organisations to provide services of a consistent nature and quality.

It is considered that the development of a MOU would ensure that the communication, information and assistance available to patients is consistent and appropriate regardless of which organisation they approach first. It will ensure that information is

up to date and accurate, enabling the establishment of strong links between the organisations and the provision of a seamless information service for patients.

Resolution through Mediation

Whenever appropriate, independent mediation services should be considered in addressing areas of disagreement or dissatisfaction between the patient and the healthcare provider.

There is currently provision in the NHS guidance for the use of mediation/facilitation. Where someone is upset or trust has broken down, an independent person can assist in a better understanding of why the complaint has arisen and prevent it escalating further. Currently mediation services can be accessed from:

CHC Advocates who have mediation skills. They act in an independent capacity and do not become involved in the complaint in any other role.
Independent Complaints Facilitators. These are trained facilitators who work with Trusts and Local Health Board when requested by the organisation.
Professional mediation organisations.

However, it is generally agreed that mediation services are underdeveloped and underused in Wales.

Recommendation 4

It is recommended that a service is developed that can provide mediation across Wales.

Advocacy Support

The most appropriate delivery of Advocacy services through the complaints and redress process is through Community Health Council patient Advocates in conjunction with AvMA. It will be appropriate in some circumstances for the patient to be referred to other services to obtain advice regarding issues arising from, though not directly related to, the NHS care around which the complaint has arisen.

It was recognised that organisations such as Citizens Advice Cymru (CAC) have expertise surrounding such issues as benefit entitlement, home adaptation which may be necessary for the patient, but which require special knowledge not possessed by either CHC or AvMA. This will apply not only to CAC but to other organisations also.

Recommendation 5

It is recommended that we build on current joint working between CHCs and AvMA to establish a cohesive and comprehensive service for patients.

The current litigation process does not allow for patient legal representatives and Advocates to work together in the management of a claim. It is recognised that co-operation between these two groups would be beneficial to the patient and provide a more holistic approach.

Recommendation 6

Advocacy and Assistance should be available to the patient throughout the pathway of a complaint, even where legal advice has been accessed through the Redress

arrangements. Legal advisers and Advocates should be encouraged to work together, where appropriate, to achieve a satisfactory outcome for the patient.

Next Steps

1. Developing the aims, objectives and standards of delivery for a mediation service across Wales in light of recommendations.
2. Review the aim, objectives and standards of delivery for patient advocacy across Wales in light of the group recommendations
3. Consider arrangements for partnership working and liaison across organisations that provide support and advocacy in Wales to establish consistent and comprehensive services for patients.
4. Formulate proposals on the appropriate delivery of comprehensive assistance and advocacy services for Wales, mapped against the proposed investigation process and capitalising on current good practice and provision.
5. Consider further the co-operation of advocacy, support and legal advice.

Appendix 2

Current Service Provision

It has been identified that the following organisations currently offer advice and assistance to patients. The services they offer are often different and at present there is a certain level of cooperation between these groups.

Action against Medical Accidents (AvMA)

Overview

AvMA is an independent charity which promotes better patient safety and justice for people who have been affected by a medical accident. AvMA defines a 'medical accident' to be where unintended harm has been caused as a result of treatment or failure to treat appropriately. AvMA believes that whatever the cause of a medical accident, the people affected deserve explanations, support, and where appropriate, compensation. Furthermore, they deserve to know that the necessary steps will be taken to prevent similar accidents being repeated.

Services Offered

AvMA has a team of medically and legally trained caseworkers who can provide free and confidential advice following a medical accident. This includes advice on a patient's rights; medical information or explanations; help in getting the issues investigated; assessment of potential for obtaining compensation; referral to an appropriate solicitor and other sources of practical and emotional support. AvMA provides a written casework service for more complex service and a Helpline.

Telephone helpline

Available between 10am –5pm Monday to Friday, charged at local rates anywhere in the UK. There is no other charge to the patient. The help line is staffed by volunteers who are either specialist medical negligence solicitors working on a pro bono basis or professionals with a medical background also working for free, the help line is based in London. The remit of the help line is to provide a first point of contact, initial advice and guidance and advice regarding the most appropriate next steps.

Complainants supported

Approximately 4,000 enquiries from all over England and Wales are managed through the help line and written enquiries. About 75% of the enquiries are referred back to the NHS complaints procedure for local resolution with advice on how to proceed.

The services are independent of the NHS and free to the patient.

Community Health Councils – Complaints Advocacy Services

Overview

The Complaints Advocacy Services are independent services provided by Community Health Councils, some on an individual CHC basis and others on a pan-federations basis.

The service provides independent Advocacy support to enable complainants to pursue a formal complaint against the NHS. The level of support required for each complainant may vary and will, in many instances, require the skills of the Advocate to analyse the issues, research and provide supporting information where appropriate and formulate letters and engage in correspondence on behalf of the complainant.

Where a complainant has difficulty in expressing their concerns or the circumstances of their complaint, or requires support to articulate the pertinent issues in meetings with the NHS, the complaints Advocate will act as their 'voice' and argue the case on their behalf.

Services offered

The available resources of the complaints advocacy services are limited and consequently the service is focused towards providing support for formal complaints. However, Community Health Councils provide information and support for patients and members of public on a range of general enquiries and informal complaints. Enquiries and a large proportion of informal complaints are handled by senior CHC officers, where advice and or intervention on a patients behalf can bring about early resolution before the issue becomes subject to a formal complaint.

Initially 15 Advocates were appointed throughout the 9 Community Health Council Federations in Wales. The current role of the Advocate is to guide the complainant through the NHS complaints procedure by giving support and advice throughout the process. Whilst patients are encouraged to retain ownership of their complaint, the support can include letter writing, attending meetings or otherwise directing the complainant to an appropriate organisation or course of action, until such time as the complaint is resolved.

The services are independent of the NHS and are free to the patient.

Quality Assurance

These services are guided by and are compliant with, the National Standards for Complaint Advocacy Services in Wales (based on ICAS National Standards as agreed with the Assembly). Although the services are spread out across Wales there is an effective and robust procedure for performance appraisal and quality assurance.

Complainants supported

In 2006-07 CHC Complaints Advocates dealt with 1,544 complaints. The first annual report of the Complaints Advocacy service found that clinical practice was the biggest cause of concern to complainants and that they wanted an official explanation of what has occurred above anything else.

Citizens Advice Bureaux

CAB is the largest integrated network of network of independent advice agencies in Wales. Each CAB offers access by telephone and have arrangements in place to provide home visiting where necessary.

Services Offered in relation to Health Complaints

Citizens Advice service has a history of supporting NHS complainants in England and has been involved in the delivery of ICAS (A statutory service providing support, help,

advice and advocacy from experienced case workers for people who want to make a complaint about their NHS care or treatment) from the initial pilot stage in 2002. They had a contract for the work between September 2003 and March 2006 but they were not awarded a contract by the Department of Health to deliver the ICAS service after 31st March 2006. ICAS however does not operate in Wales, the comparable work being undertaken by the CHCs.

Citizens Advice Cymru are required, under the Citizens Advice Membership Scheme, to provide generalist advice to individuals who have an enquiry in the field of health. In relation to the NHS complaints procedure, this could involve assistance with letter writing in the process and contact with third parties, to include Community Health Councils or appropriate solicitors with specialist knowledge of clinical negligence cases. They are active in providing advice on issues such as benefits, assessing care needs and income maximisation which may be necessary as a result of the issue around which the complaint is made.

The service is independent of the NHS and free to the patient.

Public Services Ombudsman for Wales (PSOW)

The primary role of the Public Services Ombudsman for Wales is to investigate complaints made to him by members of the public about the way they have been treated by a public body. Complaints will be investigated independently and impartially, and when upheld, the Ombudsman will say what the public body should do to make amends to the complainant and impress the need for improvement in its standard of service in the future. Lessons learned from investigations will be publicised.

Independent Complaints Facilitation

In the current NHS guidance there is provision for Independent Complaints Facilitation (ICF) to be used as one of a number of options for resolving a complaint. There is currently a small number of facilitators recruited and trained by the Welsh Assembly who can provide independent facilitation services upon request. They are both independent of the NHS and differ from the CHC advocates in that they do not also have a role in supporting the patient. Facilitators will attempt to reconcile both sides by listening to all concerns and meeting all parties with a view to trying to find a resolution and restore the patient-doctor relationship. Independent facilitation may help where, for example, staff are having difficulty dealing with a complaint; patients feel uneasy that the complaints manager is not impartial or there are misunderstandings with relatives during the treatment of a patient.

Guidance and leaflets were sent out to NHS Wales in October 2006 informing them of the availability of this service. To date however, it has not been widely used although several Local Health Boards have made preliminary enquiries about the service.

Patient Support Services

The role of PSS is principally to assist patients and carers with any concerns or queries they may have on matters relating to a service being provided in a secondary or primary care setting, particularly in circumstances where they feel reluctant to bring it directly to staff (or simply because they don't know who to raise their concern with). PSS staff have a key role in helping patients navigate their way through often complex systems and procedures and can be instrumental in resolving a concern before it escalates into a complaint.

For example, Pontypridd & Rhondda NHS Trust have a PSS and PPI (Public and Patient Involvement) Manager who will:

- be an initial contact;
- provide accurate information, advise of processes;
- speak directly to Ward staff;
- speak to Ward Manager or Practice Manager if Primary Care;
- if necessary speak directly to Directorate Manager or LHB;
- if outside agencies are necessary, liase with these, e.g. CHC, Age Concern, CAB, Macmillan's welfare officer, Caring for Carers, Social Services etc; keep contact informed at all times until concern or issue is resolved; or
- keep records of contacts for to help the Trust learn from these episodes.