



MEETING MINUTES

Complaints Advocacy Networking Group

17/18 April 2007

Metropole Hotel, Llandrindod Wells

Present:

Ruth Eaton	-	Brecknock & Radnor CHC
Kirsty Morgan	-	Brecknock & Radnor CHC (Day 1 only)
Cathy Moss	-	Cardiff CHC
Sam Perrett	-	Cardiff CHC
Wendy Orrey	-	Cardiff CHC
Janet Higgins	-	Dyfed Federation
Debbie Postle	-	Clwyd CHC
Jeff Lansdell	-	Clwyd CHC
Audrey Hughes	-	NWW Federation
Ralph James	-	Gwent CHC
Phil Williams	-	Merthyr & Cynon CHC
Helen Hardcastle	-	Merthyr & Cynon CHC
Richard Hughes-Ellis	-	Montgomery CHC
Evelina Rowlands	-	Morgannwg Federation
Jeff Lewis	-	Morgannwg Federation
John Power	-	Morgannwg Federation
Alan Griffiths	-	Pontypridd / Rhondda CHC (Day 1 only)
Debra Upton	-	NWW Federation
Liz Warren	-	Gwent CHC

In attendance:

Pat Vernon	-	PPI Branch Welsh Assembly Government
Hugh Williams	-	Deputy CEO – AvMA
Simon Dean	-	Chief Executive – Health Commission Wales
Eileen Habbijam	-	Manager - Independent Review Secretariat
Cathy O' Sullivan	-	Chief Officer – Gwent CHC
Martyn Standing	-	Board
Ann Younis	-	Board

Action

1. Apologies

Donna Coleman (Dyfed Federation), Dawn Yorke (Conwy Federation)

2. Complaints Advocate Job Analysis Questionnaire (JAQ)

The first session was facilitated by Phil Williams and Jeff Lansdell in respect of finalising the contents of the JAQ for the cluster group. It was identified that there is more than one job description for the group and this needs to be clarified. This version of the JAQ will be version 3 and needs to be endorsed by Chief Officers as line managers and then Peter Johns before it goes to Phil Trocki at the A4C project team at Powys LHB for job analysis.

It was suggested that two advocates Phil and Jeff make representation at the job analysis interview. Only one can attend, this was confirmed direct by telephone with Phil Trocki from the venue.

Richard Hughes-Ellis advised that his JAQ had already been sent directly to Phil Trocki at Powys LHB. This to be addressed as Montgomery advocate should form part of the main cluster. If undertaking other duties in addition to WAG funded advocacy post then this will constitute a separate job description and person specification for the public patient involvement work undertaken in respect of a separate service level agreement with Powys LHB.

Peter Johns

It became evident that not all COs have an awareness of the work that has been undertaken on the JAQs already. There needs to be two-way dialogue between line managers and job holders as part of the job analysis process. This needs to be remedied immediately. The remainder of the session focused on some of the issues that needed agreement by the cohort group. Many of the advocates indicated that they have little management intervention, with little supervision, one advocate indicated that he acted with the “delegated authority” of his Chief Officer. There is a great deal of inconsistency in the monitoring of the advocacy services across Wales and of the advocates operating within that service. The issue to be raised at the CO forum at the end of April.

Cathy O’ Sullivan

A host of issues pertaining to the JAQ were discussed in sequence with input from Cathy O’ Sullivan to mediate and temper some of the entries made in particular sections. Phil Williams will prepare a further version ready for circulation to all advocates and COs.

Phil Williams

It was reiterated that all COs have an open invitation to attend the

advocacy events and a number of COs have done so, particularly if there is a topic that has particular relevance at a local level.

3. NHS Redress Scheme – Pat Vernon

Pat thanked the group for the opportunity to meet with them and confirmed that everyone had received the briefing paper prior to attending the event, (copy attached). The purpose of the session was to meet with people across Wales who deal with NHS complaints with a view to improving the current system. The “Putting Things Right Project” needs to be seen in the context of “Making the Connections”. It is the intention that complaints, claims and incidents which tend to be handled as separate entities currently will be handled more effectively by April 2008 with implementation of the NHS Redress Scheme by 2009. The Chief Executive of Velindre Trust is chairing the Redress Project Board.

The first strand is the “engagement” process and existing framework powers in the Redress Act 2006 can be converted to allow for measure making powers. After the May 2007 elections, further powers will be given to the Assembly whereby it will formally split from WAG and WAG will exist as a legal entity in its own right. 2007 will herald lower value clinical negligence claims, 2008/2009 will see the WAG looking to the Assembly for cross-party support for the introduction of the measure.

Social Care Reviews are currently more efficient than NHS Reviews and the measure would be an opportunity to put them on an equally expedient footing. Unfortunately due to the completely different legislative bases of both the new powers would be unable to change this which is unfortunate.

The Speedy Resolution Scheme (SRS) in Wales has seen approximately 70 cases go through the system in a period of 2 years and the target times of 9 months have not been achieved, many are over 12 months maturity. Those who have been through the Scheme have been satisfied but numbers have been very low. The SRS is not to be confused with what the Redress Scheme is setting out to achieve. There is a huge culture change for Welsh Trusts to come to terms with in terms of accepting liability. Bro Morgannwg Trust have already put together complaints, claims and incidents teams already, this is all about taking a more patient centred approach rather than adopting a potential loss of revenue stance.

The advocates were divided into groups with regional representation in each group to discuss the different aspects of complaints. Feedback was given to the main group from the points captured on flipchart.

Group 1

1st issue How effective is Local Resolution?

Less effective in primary care than secondary care, GPs and dentists cited as problematic.

Target and focus on 2 day initial response

No focus on target for 20 day full response

Approximately 50% of complainants not happy and either give up, progress to Independent Review or the legal route.

Patients think there is a cover-up

Responses don't reflect what they really feel happened

Closing of ranks, staff left the area/hospital etc

Leads to lack of confidence in the process

Face to face meeting vary from really helpful to making a bad situation worse (the complainants attitudes can also effect this)

Dentists don't seem to be monitored, who is checking on them?

2nd issue How can LR be strengthened?

Clinicians should be more open and honest

Guidance/training should be given on how to run effective LR meetings

Correspondence should be more user-friendly and easy to understand

Letters should offer explanations not just re-state the complaint

Meetings should be more timely, longer it takes the more suspicious complainant becomes

Complete an action plan after a complaint

Better feedback to complainant

Complainants should not have to apologise for the need to complain

No admission that things went wrong

Need staff that are senior enough to authorise action

3rd issue How can LR be made more patient focused?

Barriers are put in the way e.g. applying for medical records there should be no charge to the complainant, some Trusts charge others don't, even in the same region, there is also a huge variation in charges from £10, £50 up to £189.

The complainant should be involved in the action plan

Patient should agree timescales for extensions

More informal mediation – sometimes appropriate e.g. liaison officers for patients concerns.

Group 2

1st issue What benefit does the IR add to the complaints process?

Adds benefit provided it is fair and objective

Appears to be inconsistencies in approach

Too much credence is given to the independent clinical advisor rather than looking at the complaint holistically

Are independent clinical advisors really independent?

Criteria excludes clinical views on how others would deal with it

Incredibly protracted

2nd issue How beneficial do complainants find IR

There is an independent clinical report

Provides complainants with an opportunity present their story to the panel

A constructive final report helps both complainant and Trusts/LHBs

The above is also useful if proceeds to litigation

One recommendation would be to have independent clinical report feeding into the LR stage, every LHB has access to a independent medical advisor – working out of Public Health Service for Wales.

The expertise of the IR Chair is critical

Why can't the Independent Reviewer be the Chair?

A weakness in the system is the status of the recommendations of the IR, they are not binding.

3rd issue From LR straight to Ombudsman

No-one in group had any experience yet of timescale or outcomes

Mixed responses based on existing Ombudsman track record

More objective but takes far too long under the old system, not optimistic that the new process will be any different

No going back to LR or IR if complainant not satisfied with the outcome

Unknown quantity as to how the field workers are going to have direct contact with Ombudsman's office, at least with IR there is the opportunity to make personal representation and show human side.

Group 3

1st issue Dealing with clinical negligence issues

There is no clarity of approach amongst CHCs, varies greatly

Lack of clarity within the NHS on the role and the scope of the CHC complaints advocate

Currently advise on solicitors specialising in clinical negligence from published directory

Evidence of independence of advocacy in the process

Readiness to work "together" with solicitors

Advise of possible legal cover and timescales within domestic household insurance policies

Signposting to AvMA and taking advantage of expertise as a valuable resource at CHCs disposal

$\frac{3}{4}$ of AvMAs enquiries go back into the complaints system

2nd issue CHC advocacy support in clinical negligence cases

Some advocates already actively involved in this to a degree

Further training would benefit the role to support complainants where litigation has been deemed appropriate

Useful for advocates to be able to determine from the outset suitably when case presents

Group 4

1st issue Key barriers to overcome

Poor communication within NHS bodies and between complainants and advocates

Lack of openness

Unavailability of NHS personnel to discuss concerns

Access to documentation

Mistrust of process by patients and staff – cover-up scenario

Being open “ 7 steps to patient safety” lack of staff awareness/training on content of these documents

Lack of commitment to adhere to principles recommended in these docs by frontline staff and senior management teams

Worries about raising concerns on the part of patients, particularly mental health cases

Lack of understanding

2nd issue CHC Advocacy Service Development

Involve CHC staff in NHS induction programmes but may not have enough resources to do so

Training and staff development

Common standards of advocacy

Feedback to complainants about changes made as a result of the complaint they made, this can be done via the CHC monitoring role, Trusts/LHBs have to demonstrate changes made

Make Ombudsman’s recommendations binding, no guarantee that Trust Boards implement them, they need to be enforced

WAG needs to reinforce the process of advocacy and review the different advocacy provision across the whole of Wales including peer group

advocacy, voluntary sector and the new Independent Mental Capacity Advocates (IMCAs)

Pat thanked the group for the contributions they had made which would inform the Redress Project Board. She advised that she would collate all the comments and publish a summary report, (see attached). A further questionnaire will be circulated to advocates for completion along with a request for future workshops with complainants who have used the service to gather their perspectives.

Pat
Vernon

4. Action Against Medical Accidents (AvMA) – Hugh Williams

Hugh Williams provided a refresher presentation on the role of AvMA. **(Presentation attached)**. The Board of CHCs in Wales makes a financial contribution to the organisation which is a registered charity and a number of advocates regularly use the services that AvMA make available. Hugh has had involvement in a legal context in Wales for sometime both in the Speedy Resolution Scheme development working group and as a member of the NHS Redress Scheme Project Board.

5. CAMS Annual Report 2006/2007 – Martyn Standing

The Research Officer provided the preliminary figures on an all Wales basis for the Complaints Advocacy Service with the exception of one complete data set from Gwent CHC. Figures were presented on a federation basis as opposed to individual CHCs. **(A copy of the presentation is attached)**. Once Gwent figures are submitted the full draft report will be circulated to CHCs for comment. Some comparative complaints data from NHS Wales would be useful. Pat Vernon to be approached for this.

Martyn
Standing

6. File Retention Period for Complaints

All complaints files need to be stored securely for 10 years.
Maternity related complaints for 25 years.

The majority of advocates are concerned that there is insufficient space available for secure file retention and have requested that a central storage facility be sourced including confidential transportation. Issue to be raised with the Director.

Peter
Johns

7. Case presentation – Dental – Audrey Hughes

A multiple complaints scenario in respect of the same dentist was presented to the group. **(Presentation attached)**. Contributions

from the group included making contact with the Dental Practice Board, contact 01323 433550, which invites patients from different dental surgeries to attend for an independent assessment. Useful resource for gleaning a second opinion. Another route to explore would be NHS Fraud Investigators to determine if there are any financial irregularities in association with inappropriate treatment. Trusts and LHBs dental practitioners are regulated by the Dental Council's Code of Practice, useful to secure a copy. Finally the BSC is another avenue of exploration in respect of clarification on treatment.

8. Case Presentation – Overseas Treatment – Jeff Lansdell

This case involved a small child who had experienced difficulties with feeding since shortly after his birth. Doctors had failed to identify the cause of the problem and adopted an “it will right its self in time” attitude. The parents were concerned as they witnessed on a daily basis their son regurgitating any feed he was given and his development and well being affected. They tried all avenues open to them in the UK to find a solution to the problem. This included taking their son to Great Ormond Street Children's Hospital in London without success. The parents saw a program on the television showing pioneering work being carried out at the University Hospital in Austria and read an article written by the parents of a child who had been successfully treated at the clinic. The parents tried to obtain the support of Clinicians in the UK for their son to be referred to Austria for treatment. One of the reasons given was that no NHS body had supported this treatment and it was seen as experimental. Eventually they paid for the treatment themselves and returned from Austria with their son having made amazing progress. Shortly after they returned to the UK they discovered that one of the Liverpool PTCs' had funded treatment for a 10 year old child from their area. The parents have been informed that a retrospective claim to assist with the costs of the treatment would not be entertained by the Local Health Board. With the assistance of AVMA we are examining the options open to the family to pursue reimbursement of the treatment costs.

This presentation prompted animated discussion amongst the group. It is surely an example of how advocates can be a conduit for sharing good practice and knowledge across a clinical group. Positive outcomes for this one may be twofold, in the first instance financial reimbursement for the parents to cover treatment costs but more importantly the availability of the treatment in the UK.

9. Mental Capacity Act 2005 and the Independent Mental Capacity Advocate (IMCA) – Ann Younis

The Mental Capacity Act 2005 provides a statutory framework for people who may not be able to make their own decisions for reasons such as brain trauma, mental health issues, illness such as dementia or individuals with a learning disability.

The Act sets out who can take decisions, in which circumstances and what process they should follow. The Act also creates a new service, the IMCA whose role it will be to help vulnerable people who lack capacity and who are facing important decisions made by statutory bodies such as the NHS or Local Authorities in respect of serious medical treatment or changes of residence.

Where an individual has no family or friends the IMCA has to be consulted by NHS bodies or Local Authorities with regard to serious medical treatment or changes of residence, there are exemptions however, such as someone who have an enduring Power of Attorney, a Lasting Power of Attorney or an appointed deputy under the Act.

The Act specifies the principles that must be applied by everyone who is working with or caring for adults who lack capacity. England has already piloted sites and is now live with the service and rolling out training to IMCAs. Wales is currently undertaking work through Local Health Boards and Local Authorities to provide the service with a view to implementation in October of this year. A presentation on the Mental Capacity Act was delivered (**see attached**) and Susan Elsmore at the WAG will be meeting the advocacy group in September at the next networking meeting to provide an update on the IMCA service in Wales. The Department of Constitutional Affairs has produced and gone to press with a series of booklets which have been ordered for advocates but not yet received. They will be distributed on receipt.

Ann
Younis

10. Health Commission Wales – Simon Dean

As a result of the increase in commissioning based complaints across Wales, Simon Dean, Chief Executive of HCW agreed to address the advocacy group. The timing was not conducive given that the event coincided with the purdah period with the run up to the elections. HCW is the largest commission in Wales with a budget of £530 million and is not an NHS body. It is the only Executive Agency of the WAG. It's legal status means that it is not a statutory body and could be abolished tomorrow. This creates an interesting dynamic with the Minister! Simon

is line managed by the Chief Executive of NHS Wales, Ann Lloyd. Everyday business and decisions are based on policy without the need for Ministerial submissions. Simon is directly responsible for the financial affairs of HCW and the Board is a stakeholder one therefore all decisions made by HCW are made by Simon. The Board is made up of a range of people, such as Peter Johns, the Deputy Chief Medical Officer and three Chief Executives from LHBs, one from each region. The Board does not have decision making powers or responsibilities, governance arrangements are interesting but complex. It is difficult managing 22 LHB relationships because there are 22 of them!

A Statutory Instrument supported by a Welsh Health Circular sets out the descriptions of what HCW should commission such as the Ambulance Trust because it is an all Wales service, all Wales screening programmes, neuro services, plastic surgery, much of cancer but not all, much of cardiac care but not all. HCW has a really wide portfolio of commissioning responsibilities, some are very poorly defined. There are 52 posts in HCW, 20 substantive, the rest secondments and agencies, other than the main office, 2 people are based in north Wales regional office and one in Carmarthen.

HCW deals with 2000 individual patient referrals each year. This is a ridiculous figure and volumes of this magnitude should only occur when there are exceptional cases, e.g. no contract exists for the provision of care, use of new technologies or regimes.

Simon indicated that he is now in the unenviable position of having to pay back budget overspends for the next four years as there is no NHS growth money anymore. He invited the group to suggest who spends the money in the NHS, the commissioner, the provider or the clinician - the clinician.

HCW has to make some tough decisions on funding issues, there has to be an approach to priority setting decision making which is not always popular. The elements that need to be taken into account include:

- Evidence
- Comparability
- Ministerial direction
- Service and Financial Frameworks (SaFF)
- Court directives
- High secure units – public protection

Most of the £530 million is tied up in Welsh NHS Trusts in contractual services, almost £380 million, there is a £130 million contract with UHW

alone. It is important that HCW has a strategy and sound commissioning policies. Mapping patient flows has proved to be difficult and erratic and gatekeepers are needed at the referral stage.

This is the current scenario:

Patient seen at Welsh NHS Trust

Clinician refers to English hospital – patient expectations raised

Funding letter received at HCW from English provider – patient expectations still elevated

HCW refer to the body seeking funding and refuse to pay – patient made aware and case ends up in advocacy caseload and / or adverse media.

HCW is trying to work with LHBs to put a mechanism in place so that the patient is not subjected to the elation / deflation effect by putting in place gatekeeper arrangements which will result in better health value.

Another example would be CAMHS / Eating disorders

The community based model is more effective than a specialist unit. The Wales service pathway has huge void due to the lack of Level 2 care.

Pressure is being applied for the provision of patient placements in specialist units. Regional commissioning should resolve this issue.

Public subscription retains the Children's hospital in Cardiff yet still patient flows are evident in Bristol. Adult neurosciences, currently two sites, both cannot be clinically maintained because the population in Wales is not there to support such specialist provision. HCW is currently working with consultants to make more of them specialist and creating a database where they and sub-specialists can be recorded and the information and Welsh knowledge shared, this will have a particular impact on brachicardia, gender re-assignment and bariatric specialist provision.

There are two major issues for specialised services, they cannot be provided everywhere and the money needs to stay in Wales. £70 million was spent in England as a consequence of payments on results.

Challenging HCW decisions

Individuals and advocates can complain direct to HCW

There is an Independent Commissioning Panel which meets on a monthly basis.

An External Review Panel can only review the process as to how a HCW commissioning decision has been arrived at, not the decision itself.

Simon concluded his session by inviting any further questions and

reassuring those advocates who have problematic cases to make direct contact with him to discuss the issues which were case specific.

11. Independent Review Secretariat – Eileen Habbijam

Eileen is acutely aware of the difficulties with the Secretariat of the late. Due to so much discontent amongst the advocacy group with the IR stage that as the first part of the introduction was the clarification of the lay member accountability to the Assembly and Ombudsman only. The Assembly is keen to broaden the use of panel members across Wales but members are reluctant to travel. The three regional offices tend to use lay members most local to the area. Reimbursement fees for lay advisers, reviewers and chairs were discussed. If there is a resource issue in one area it will normally have a knock on effect in another, especially office staff.

Accounting for delays in the process

Complainants don't give consent to proceed (direct cases not via CHC). Obtaining clinical experts – lists from Assembly date back to 1996 and outdated. Experts for some specialities just cannot be found for this work. Some of the experts can take 3 months.

Cost of clinical GP advice £175 per day (not per case)

Complaint against Trust - Trust picks up the tab

Clinical Assessors – circa £600/£700

NHS consultants need to give 8 weeks notice to Trust to attend panel as a clinical assessor – Assembly needs to intervene on this

The costs of the IR Secretariat (part of the BSC) whole service running cost is £400K. Trusts element for clinical experts is £70/£75K.

Current data 2006/2007

260 requests for IRP

179 Trust related

81 LHB related

1 Independent

Those that went to panel – 10 (equates to £1800 per request)

The current process has been in place for 4 years.

Advocates are concerned that so many are being thrown back for LR.

This is frustrating as this would already have been exhausted as a rule.

Eileen suggested that an in-house process would be much more efficient as far as clinical assessors were concerned. Some advocates noted that there appears to be discrepancies in the extent of the IR files. This has impacted negatively on particular cases when fullest information is

available and not being utilised. A recent action was recommended by IR but it had already taken place, that would have been evident if the full case file had been scrutinised. Eileen will check with all the offices to ensure there is consistency in the documentation requests.

Eileen
Habbijam

Anonymised IRP reports not being received, the anonymised should go to the CO and the full report direct to the advocate. Eileen will pursue with the Information Governance Manager.

Eileen
Habbijam

Joint complaints

A recent health and social services complaint (SS has to sit within 20 working days) a demand was made by the SS panel that all SS annotated notes be collected in after the IRP. Why were these documents retained, it would have disadvantaged the Ombudsman from a health perspective?

Eileen
Habbijam

Multiple complaints against the same clinician

The same Dr was involved in 3 separate complaints brought by 3 patients. Should the case allocation not go to the same IR Chair? The response to this was that it is not up to the IR Secretariat to identify trends it is outside their remit.

Concern expressed by advocate that IR clinical advisor needs to have a greater awareness of the role of the advocate. Instance was documented in the IR report that the advocate was “confused”. This being taken up as a separate issue directly with Eileen.

The IR Secretariat has no responsibility for monitoring the decisions of the IR panel members. This is the jurisdiction of Pat Vernon and any concerns in respect of lay member performance should be directed to her.

The Assembly has a duty to monitor Action Plans that result from panel recommendations. The panel Chair makes the decisions about who he wants to see, why and at what time. The Secretariat has no jurisdiction over this. If a Trust is called upon to attend a panel they are under no obligation to do so. A dim view however would be taken if they failed to materialise.

12. Update on advocacy caseload in respect of prisons

Morgannwg Federation reported that the one that they have received was dealt with without the need to visit the prison, all done through correspondence. Swansea Trust have received 5 but no involvement with the CHC advocates. The new prison governor doesn't see why the in-house system should change but is progressing a protocol with the CHC.

Cardiff & Vale Cardiff CO sitting on the prison Board. The advocates have met with the prison governor. They have agreed in principle that they will undertake the role. 1 telephone call received todate.

Gwent None have come through CHC, advocates working on protocol currently.

13. AOB

Organise Root Cause Analysis (RCA) training with NPSA for next event.

Debra, Ruth, Liz, and Richard to provide case presentations for next event.

Action Plan

Action Point	Initials	Completion Date
Check status of JAQ submission to Phil Trocki	Peter Johns	May 2007
Raise Quality Monitoring of Advocacy Service and mechanisms used with other COs at CO Forum	Cathy O'Sullivan	26/27 April 2007
Circulate revised JAQ in readiness for CO Forum	Phil Williams	20 April 2007
Questionnaire to be distributed to advocacy group to inform the Putting Things Right Project	Pat Vernon	By June 2007
Approach Pat Vernon for NHS Wales complaints statistics for 2006/2007	Martyn Standing	By June 2007

Requirement for secure storage of archived complaints files in accordance with retention guidelines	Peter Johns	July 2007
Distribution of Mental Capacity Act booklets on receipt from Department of Constitutional Affairs.	Ann Younis	ASAP
Progress all action points arising from advocacy session	Eileen Habbijam	June 2007

7. Next Meeting arrangements

Date of next Meeting: 20/21 September 2007 (Venue not available for 19/20)

Time of next Meeting: 10.45 am registration

Venue of next Meeting: Lake Country House, Llangammarch Wells

Minutes submitted by: Ann Younis

Minutes signed by :