GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Annual Concerns & Claims Report

2016-2017

EXECUTIVE SUMMARY

The annual Concerns and Claims Report provides details on the Health Board's performance against the requirements under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. *This is the fifth report the Health Board has completed.*

2016/17 was the third year of the Patient Experience, Risk and Legal Services merging as one team with a focus on:

- Individually acknowledging every complaint and the complainant, where possible, spoken to via telephone to discuss their complaint;
- Increased openness and involvement with the patient/family representative throughout investigations;
- Continuation of the "Lets Talk Campaign" which is designed for patients and staff to speak up and report concerns so that the Health Board can continually learn and improve the services we provide;
- Continual development of the Datix Web Risk Management Database to enable real time data and ensure it remains fit for purpose. This work has resulted in the Health Board being awarded reference site status in recognition of the development of the system and the Health Board has maintained this during 2016/17.

The Health Board received 1,249 formal complaints which is a slight decrease (3%) when compared to 1,290 complaints being received in 2015/16. Informal complaints have slightly increased (0.18%) from 1,099 received in 2015/16 to 1,101 during the year.

During 2016/17 the Health Board has embedded the revised operational arrangements moving from 12 Directorates/Localities to six Delivery Units each with supporting governance teams:

- Mental Health & Learning Disabilities Unit
- Morriston Hospital Unit
- Neath Port Talbot Hospital Unit
- Primary Care & Community Services Unit
- Princess of Wales Hospital Unit
- Singleton Hospital Unit

The aim of the re structuring was to develop an organisation service of its front line staff – caring for each other, working together and always improving to achieve the following:

- To be patient-facing, based on how patients experience our services rather than specialties or professions;
- Accelerate progress on new models of primary and community care, shifting the balance;

- Be easier to understand for staff and patients;
- Improved visibility for staff - fewer “layers”, shorter lines of communication between senior management and frontline teams
- Create clarity about who is responsible and accountable at all levels and on all sites;
- Allow more devolution of responsibility and decision making to local teams;
- Be a better framework for joined-up working about service improvement, major operational challenges and performance issues; and
- Have more local ownership and clinical engagement.

As a result of these changes, and following consultation with staff within the Patient Experience, Risk and Legal Services Team, the management of complaints and staff were relocated to the Units in 2016/17. This change was made to support timely, quality investigations promoting lessons being learned at the earliest stage locally and then shared within the Health Board.

During the year key themes, from concerns which were upheld, related to:

Communication Issues	38%
Clinical treatment	11%
Appointments	9.9%

Communication was the top theme for 2015/16 and remains the top theme for 2016/17. Communication accounted for 38% of the complaints upheld in 2016/17. As a result of which action has been taken to review and improve the documentation we use, the information we provide to carers and increased joint working with partners.

As the most common reason for complaints is communication, the below information sets out the action we are taking to reduce the likelihood of complaints:

- **Training**
  As a consequence of the continuing theme of Communication in complaints received, the Patient Feedback Team (PFT) have concentrated delivering training for staff on nipping complaints in the bud, and Communication with a discreet focus of a behavioural change. Bespoke training sessions for areas that identify continual themes of communication are being undertaken.

- **Health Board Values**
  A pilot study is being undertaken for the next 6 months on Bereavement by a counselling team. In Morriston SDU the Complaints team are working to support bereaved relatives who make a complaint about the care and treatment their relative received.

- **Patient Advice Liaison Service (PALS)**
  The 3 Acute Hospital Sites have PALS teams in place and there is a Patient Experience and Advice Service (PEAS) Team in Neath Port Talbot Hospital. In

2014 a decision was taken to introduce and pilot Patient Advice and Liaison Service in Princess of Wales Hospital to provide a far greater focus on Patient Experience. PALS Teams are able to provide a visible face to patients, wards and departments.

Clinical treatment was the second highest theme with 11% of complaints in this theme, with the majority relating to delay in receiving treatment.

Appointments was the third theme of the most upheld complaints with 9.9% of complaints upheld. Improving the areas of our services is one of the six strategic aims of the Health Board to take forward and a number of actions are being taken to improve performance. While there has been some improvements in terms of reducing the number of patients waiting for a first appointment, and waiting for treatment, the Health Board recognises that further work is required to reduce the waiting times further and the Board is taking action in this respect. Improving access to services for patients remains a priority for the Health Board.

Further information on the action being taken to improve waiting times for appointments and treatment is provided in the Health Boards Annual Report which can be accessed through the Health Boards Intranet: www.abm.wales.nhs.uk

Looking back in terms of external investigations and reports relating to concerns and claims management the Health Board has had:

- No new public interests (Section 16 / 17) Ombudsman Reports received in 2016/17 compared to one being received in 2015/16.

- Four Regulation 28 reports were issued by Her Majesty's Coroner in relation to inquests involving the Health Board where the Coroner recommends action is taken to prevent future deaths occurring. Please see section 18 for more details of these reports and the action the Health Board has taken.

All concerns provide an opportunity for learning and they are a valuable method of us knowing where we can improve. We want to reduce these wherever possible and to give patients and our staff a service they can be proud of. Section 12 of this report provides details of some lessons learned/action taken to help minimise recurrence following investigations of concerns.

The report sets out the organisational arrangements for the management of concerns. It also details the number of cases managed within the period and whether they arose as patient safety incidents or as complaints. Setting this information against the number of patient contacts we have as an organisation demonstrates that complaints and incidents are rare and that the vast majority of the people we see are satisfied with the care and treatment the Health Board provides.

1. Background to the NHS Redress Regulations 2011

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 came into force on the 1st April 2011. These Regulations apply to all Welsh NHS bodies, primary care providers in Wales and independent providers in Wales providing NHS funded care. The Redress elements of the Regulations and the guidance relating to those aspects do not apply to primary care practitioners or to independent providers.

These regulations require a proactive approach to acknowledging and putting things right when patients have suffered harm or poor experience. They were designed to streamline the handling of Concerns. Under the new *Putting Things Right* arrangements, ABMU Health Board has improved its performance against the principles of the guidance, to "investigate once, investigate well", ensuring that concerns are dealt with in the right way, the first time round. Concerns are issues identified from patient safety incidents, complaints and, in respect of Welsh NHS bodies, claims about services provided.

2. Arrangements for the handling of concerns

The Health Board's Non Officer Member who has oversight for the handling of concerns in 2016/17 was Mr Paul Newman and was also the Chairman of the Quality & Safety Committee. Mr Newman's role is to ensure the Board is provided with an appropriate level of assurance in respect of managing concerns.

The Director of Nursing & Patient Experience is responsible for ensuring compliance with NHS Redress and is supported by the Deputy Director of Nursing & Patient Experience. While the Director of Nursing & Patient Experience has direct responsibility for the management of the Department the Medical Director and the Director of Nursing & Patient Experience share responsibility providing leadership and support in the handling of concerns and claims.

In 2016/17 revised management arrangements were implemented with six Directly Managed Units replacing the eleven Directorates and Localities management arrangements. The role and function of the Patient Feedback Team, in regard to concerns management, was reviewed and revised to support the management arrangements in the Strategic Delivery Units. The focus of the Units is responding to concerns with quality, timely responses, ensuring shared learning across the Units as a priority. The Patient Feedback Team support the Units in terms of strategic direction and performance management in terms of improving the quality of responses to complains and improving the timeliness of the responses issued.

3. External Assurance – Welsh Risk Pool Assessment

Welsh Risk Pool Services (WRPS) is a mutual organisation which provides indemnity to all Health Boards and Trusts in Wales. It reimburses losses over £25,000 arising out of claims for negligence and is funded through the NHS Wales Healthcare budget.

In addition to the reimbursement role, WRPS undertakes annual risk management assessments, including one which looks at arrangements for the management of concerns and claims. Their assessment findings are captured under three primary headings:

Concerns Management
To ensure that all NHS bodies have an effective process for managing concerns raised by patients and staff in accordance with the NHS Redress Regulations.

Compensation Claims Management
To ensure that Health Boards have an effective process for managing legal claims for financial compensation brought against them by patients and staff.

Learning from Events
To ensure that good organisational learning arises from all events,- including concerns and compensation claims.

The Welsh Risk Pool did not complete an assessment of Health Boards in 2016/17. Instead reliance was placed on the Internal Audit report of Claims Management which recorded a "green" assurance rating of **substantial assurance**. The assessment scores for previous years are presented in Table 1.

Table 1: Welsh Risk Pool Assessment – Concerns & Claims Management Standard

Area for Assessment	2011/12 Scores	2012/13 Scores	2013/14 Scores	2014/15 Scores	2015/16 Scores	Variance
Concerns Structure *	-	-	-	-	91.5%	-
Concerns Management*	-	-	-	-	66.28%	-
Concerns – Informal*	-	-	-	-	70.25%	-
Primary Care Concerns*	-	-	-	-	68.5.%	-
Redress*	-	-	-	-	74.13%	-
Compensation Claims Management	77.19%	87.62%	80.62%	84.43%	95.43%	+11%
Learning from Events	40.67%	53.08%	33.40%	48.25%	49.91%	+1.66%

* The Standard used for the assessment in 2015/16 has considerably changed and as a result a direct comparison is only applicable in two areas; compensation claims management and learning from events.

The Health Board is focusing on learning from events and has established improvement groups for pressure ulcers and falls which account for the majority of incidents reported. In 2017/18 regular continuous newsletters will be produced and issued in the Health Board focusing on learning from Healthcare Inspectorate Wales inspections, serious incidents, complaints and claims.

4. Concerns - Safety Incidents

A total of 17,207 patient/visitor incidents were reported during the year the majority of which, related to no harm incidents (80%). The degree of harm and level of harm is provided in Table 2.

Table 2

Table	**Green**	**Yellow**	**Amber**	**Red**
Incident Reported Date	**No/V Low Harm/ Damage**	**Minor Harm/ Damage**	**Moderate Harm/Damage**	**Severe/V Severe inc Death**
2008/9	**69.89%**	**25.63%**	**3.47%**	**1.00%**
2009/10	**72.00%**	**25.45%**	**1.80%**	**0.76%**
2010/2011	**75.92%**	**21.40%**	**1.84%**	**0.77%**
2011/2012	**87.60%**	**10.60%**	**1.02%**	**0.68%**
2012/2013	**89%**	**8.50%**	**0.98%**	**0.74%**
2013/2014	**89%**	**8%**	**1.56%**	**0.66%**
2014/2015	**84.42%**	**13.04%**	**2.18%**	**0.35%**
2015/2016	**81.7%**	**14.6%**	**3.2%**	**0.32%**
2016/17	**80%**	**17%**	**3.3%**	**0.34%**

The Health Board purchased Datix Web Risk Management database during 2014/15 and implemented the system on 1st December 2014. As a result staff, following completion of incidents receive automatic feedback when the incident is closed setting out the lessons learned and actions taken. Staff were consulted with the design of the incident form as a result of which there has been an increase in incidents reported which provides the Health Board with an opportunity to learn lessons from no harm incidents.

It is also compulsory for feedback to be a specified action in any action plans developed in response to complaints, incidents and claims.

5. Serious Incidents

The Health Board submits details of 'serious incidents' to the Welsh Government. Welsh Government define a Serious Incident to include incidents where there is media interest, 'never events' (such as chemotherapy drugs given via the wrong route, wrongly prepared high risk injectable medication, maladministration of Insulin) and unexpected deaths. The reporting criteria are not based purely on the level of harm.

During the year, 223 serious incidents were reported to Welsh Government, these included pressure ulcer incidents, reports of bed closures due to outbreaks of infection within our hospitals.

ABMU introduced a standard operating procedure for the investigation of never events and serious incidents in January 2015, which was reviewed and updated in 2015/16, to ensure rapid investigation and reporting of never events, resulting in timely actions being taken and learning within the Health Board.

5.1 Never Events during 2016/17

During the year 4 incidents occurred that we call 'Never Events.' These are incidents that all NHS organisations should have robust systems and processes in place to prevent them occurring. All events have been fully investigated and as a result changes are being made to improve patient safety.

These events related to the use of the wrong surgical components being used in two instances; one related to the management of a naso gastric tube and the fourth one related to wrong route medication.

The Health Board accepts that these events should not have occurred and has taken action as a result of the findings in the investigation reports and shared these with the patients/family involved. The learning from these events includes:

- Entire programme of theatre improvement worth to ensure we meet National Safety Standards for Invasive Procedures (NatSSIPS);
- NatSSIPS Task & Finish Group chaired by the Medical Director to ensure compliance with Patient Safety Notice 034 and;
- Naso Gastric Management Task & Finish Group to ensure compliance with Patient Safety Alert 008 which is chaired by the Deputy Medical Director.

6. Concerns – Complaints

Complaints can be received at any place across the organisation, and not all complaints are resolved using the formal process. The Health Board is required to report performance against compliance with the timescales recommended within the NHS Redress measure and via the Putting things Right Guidance. A grading system is in

place which considers the severity of the concern to promote a suitable level of investigation to be undertaken.

Concerns graded-
Green or yellow, or Multi yellow are subject to 30 days maximum target timescale, this can be extended in complex cases as is often the case in Multi yellow concerns

Amber/ Red are subject to a 30 day target timescale although often these graded concerns are complex and in such cases the timescale for investigation can be extended to 6 months, although the Health Board, where possible, will aim to complete the investigation within 30 days.

Performance in relation to timely complaint responses is provided in 6.2.

6.1 Developments lead by the complaints team include:

- **Revision of Corporate Patient Feedback Team**

  During 2016/17 the repatriation of staff from the corporate team to the quality & safety Teams in t he six Service Delivery Units was completed. The revised arrangements will enable the Service Delivery Units to investigate their own complaints encompassing all grades of concerns. The rationale for this change is to ensure complaints are investigated promptly and to take forward actions to improve care and services for future patients and share the learning across the Health Board.

- The Corporate Complaints Patient Feedback Team participated in a pilot scheme within the Health Board with the bereavement team, as evidence suggests that a significant number of complaints in hospitals are related to death and early intervention from the bereavement team can support and help families in coming to terms with a bereavement. This helps families to have a better understanding of the events that led to a death and support families more where they wish to make a complaint.

- The Health Board continues to work with external stakeholders eg the Community Health Council (CHC). The Deputy Head of Patient Experience and Concerns holds regular meetings with the Deputy Chief Operating Officer to improve and develop working relationships. The aim of the meetings are to jointly review the CHC complaints sent to the Health Board to share information, identify trends and to support good working relationships between the two organisations.

- The Corporate Patient Experience & Concerns Trainer, as a consequence of the continuing theme of Communication in complaints upheld, has concentrated on delivering training for staff on “nipping complaints in the bud”. Also the training covers behaviours and behavioural change. Bespoke training sessions for areas

identifying continual themes of communication have been completed across the Health Board.

- A Concerns and Redress Assurance Group is in place to audit and monitor complaint response compliance from the 6 Service Delivery Units. Feedback and learning form this group is reported at the Assurance and Learning group meetings.

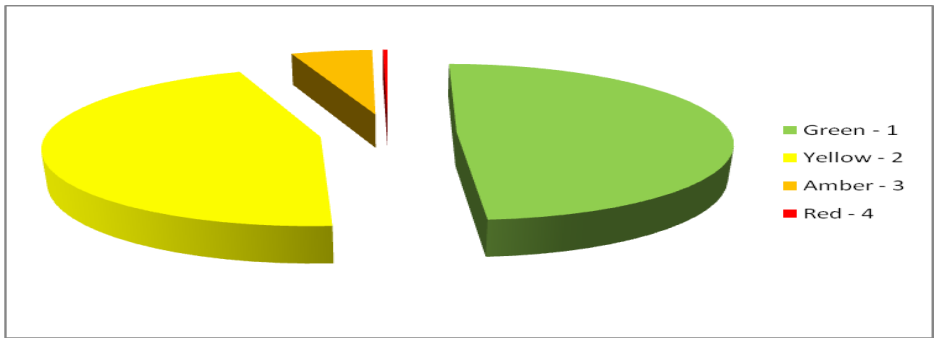
- Workshops and training has been delivered to support the Service Delivery Units in the management of concerns and redress cases. The workshops promote an ethos for good investigation of complaints and complainant responses and the importance of timely responses. The Ombudsman Improvement Officer has attended a number of the workshops enabling an improved understanding of the Ombudsman role.

- The Health Board continues to operate a process with the aim of contacting complainants on receipt of a concern, and a meeting offered to the complainant. Complainants are now updated regularly on the progress of the complaint.

6.2 Complaints – Activity and Performance

During the financial year of 2016/2017 the Health Board received 1,249 formal and informal concerns totalled 1,101for the year.

Below is a pie chart which reveals the grades of formal complaints received during this reporting period.



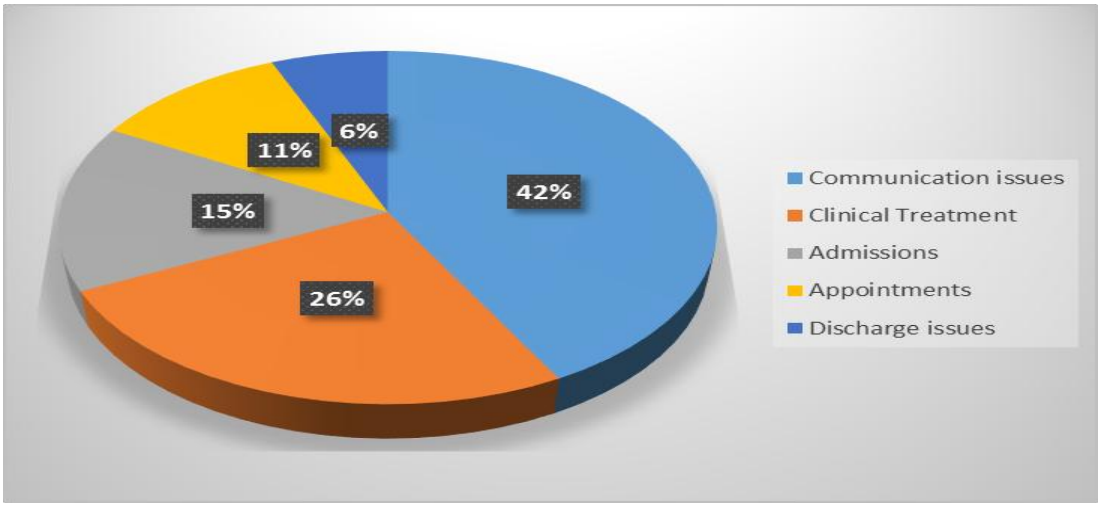
Green	48.84%
Yellow	45.35%
Amber	5.5%
Red	0.3%

As you can see the majority of concerns received are severity graded Green and Yellow due to the contents of the complaint information provided in terms of harm. Many complaints have more than one element of dissatisfaction, although each complaint tends to have a primary subject.

6.5 Type of Complaint Received

The top five types of complaints received are provided in the pie chart below, 35% relate to communication issues, and access to services (including appointments (17%) and admissions 11%) account for 28% of complaints received.

Top 5 complaint themes



To meet the requirements of the NHS Redress Regulations, the Health Board aims to respond to complaints within 30 working days. If there are reasons why this cannot be achieved – for example in cases where the complaint is serious or requires a full investigation to be undertaken - a reasonable timescale is agreed with the person raising the complaint. This should be no longer than 6 months.

The Health Board's compliance with those concerns expected to achieve a response within 30 working days was 54% which is an increase of 10% compared to 44% achieved in 2015/16. The Health Board will aim to improve performance in 2017/18 and actions to do this have already been taken during the year which has started to see performance improve. The last quarter of 2016/17 (January – March 2017) saw the performance increase to 74% for this period and priority in 2017/18 will be to continue to improve our performance and the quality of responses provided to complainants.

7. Compliments

A total of 2,664 compliments were recorded in 2016/17 compared to 1,491 in 2015/16, compliments recorded on the Health Board's database representing an increase of

60%. Compliments recorded include: formal letters/correspondence expressing gratitude and appreciation for treatment. Many more cards, letters, and gifts were also sent directly to clinical teams and wards from grateful patients and relatives, which have not been formally recorded.

Here are some extracts of the compliments we have received about our services during 2016/17.

Princess of Wales Hospital
So often letters are written to complain about services and care provided and I was no exception to that rule when I wrote to you in 2014 regarding the appalling care my mother was subject to towards the end of her life in some wards at POWH.....Since the death of my mother, dad has been a regular service user and initially he was very anxious about this in light of our previous experiences. .....
During the time we as a family have been using the services of POW, there has been a considerable change in terms of culture and practices in the hospital and we feel that other service users in and around the vicinity are now benefitting from this. However, I am sure you realise there is no room for complacency and there is still more to be done. We would like you to extend our heartfelt thanks and gratitude to all those concerned and involved in caring for Dad and be assured we will continue to support all those involved in continuing to improve local services.

Llynfi Ward, Maesteg Community Hospital
'I wanted to write to you to tell you about the amazing care that mother was given while in your hospital.
My mother was very ill, had a massive stroke and developed pneumonia. The care that she received was above and beyond from the cleaners up to the sister and everyone in between. Mam went up to Maesteg on the 18th March but sadly died there on the 24th April. I could not have wished for her to be anywhere else than in Maesteg, they showed compassion, empathy, respect and they also looked after the family. I cannot thank them enough. I hope that you will let them know what a wonderful job they all do, they work tirelessly and are always smiling.
If ever I need looking after when I'm old I hope I'm lucky enough to go to Maesteg Hospital.

Y Bwthyn, Princess of Wales Hospital
'Thank you seems hardly enough for all the care, attention and thoughtfulness you showed to S**** and myself. During his last few weeks you treated us both with kindness and respect. You helped his passing to be a dignified, pain free and peaceful one. All the staff showed love, respect and dedication way beyond what is expected. For all that you did for S****, from the fairy lights to making it possible for him to spend time outside. I can never thank you enough. You are all true angels and will be in my thoughts and prayers always. Again. THANK YOU'

Onnen Ward, Cefn Coed Hospital
(Excerpt)
'This brings us to today where Mum and Dad are reunited at home. Mum is very frail and at 63yrs of age, is not the way that I envisaged my Mum and Dad's retirement to be. However, they are happy and safe in their home and my Dad is Mum's full time carer with the help of wonderful carers from the North Hub (based at Garngoch) calling four times a day.
I would just like to finish by saying that all the staff that work at Onnen do a fantastic job in sometimes very difficult circumstances which can change by the minute. My father and I will always be extremely grateful to Dr - - and the staff at Onnen ward for everything that they have done for our lovely Mum and would recommend them for a special award in recognition of the continued high standards of care, compassion,

I have to say the standout person for me on our stay was the playroom leader. She is such a credit to the team here – going above and beyond what I expected. My son couldn't play so she brought things to him, made toast if he didn't want lunch, made a sticker chart to encourage him to eat and really made an effort. I felt really supported by these little gestures. What a wonderful person she is!!
Oakwood Ward, Morriston Hospital

8. Referrals to Public Service Ombudsman for Wales

During 2016/17 the Ombudsman received 94 complaints about ABMU Health Board, 21 complaints less than the previous year representing an 18% reduction. Of these complaints 26 proceeded to investigation, a reduction of 25% from the previous year when 44 complaints were investigated. 42% of these complaints were upheld in whole or part by the Ombudsman, or resulted in other action like a voluntary settlement. This is a 17% increase from the previous year.

There have been no Public Interest Section 16 reports for the Health Board for this period.

The main themes from the Ombudsman continue to include in-hospital treatment, poor complaint handling, missing records and/or poor record keeping, poor communication; poor end of life care and poor discharge processes.

9. NHS Redress

Under the NHS (Concerns, complaints and Redress Arrangements) (Wales) Regulations 2011 arrangements, the Health Board is required to identify those complaints where the investigation finds that harm has been caused because of a breach of duty of care. In these cases, the Health Board is required to offer Redress to the person, which can comprise of :

- a written apology;
- a report on the action that has been taken, or will be taken, to prevent similar concerns arising;
- the giving of an explanation and
- the offer of financial compensation (up to the value of £25,000) and/or remedial treatment, on the proviso that the person will not seek to pursue the same through further civil proceedings.

During the year the Health Board considered 98 (79 complaints and 19 incidents) compared to 158 cases in 2015/16 under the Redress process.

Due to the nature of the Redress process whilst these concerns will have had a response, consideration of Redress or acceptance of the Redress Offer was ongoing at the end of the year and will be resolved during 2017/18.

The Health Board settled 72 redress cases (69 complaints and 3 incidents) in 2016/17 compared to 66 redress cases during 2015/16.

Training on redress continues with the Legal Services Team providing training to Directly Managed Unit teams as part of Managers training on the Managing to Deliver Programme on a quarterly basis and six monthly to clinicians on the Consultant Development Programme. In addition Concerns and Redress Workshops have been held during 2016/17 to support the Units in complaints and redress management.

10. Claims

In addition to those cases settled under the Redress process, the Health Board continues to receive new Clinical Negligence and Personal Injury Compensation Claims. During the year 187 Clinical Negligence Claims were received compared to 203 claims received in 2015/16, 8% reduction and 239 claims were received in 2013/14.

The Health Board also received a total number of 55 Personal Injury Claims in 2016/17 compared to 88 cases received in 2015/16 and 86 in 2014/15.

Some of the themes arising from Clinical Negligence and Personal Injury Claims include:

- Failure/insufficient monitoring of patient
- Failure/missed/delayed diagnosis
- Inappropriate aggressive behaviour to staff by patients
- Treatment/procedure incorrectly performed

There are a total of 698 claims active on the Health Board's databases at the time of reporting (07/07/2017).

10.1 Priorities for improvement (Claims Team)

The findings of the Welsh Risk Pool Standard assessment in 2015/16 have been fully considered and an action plan developed to improve compliance against the Standard which includes the compilation of Standard Operating Procedures to ensure consistency with Redress responses within the Claims Department and Directly Managed Units and continuation of training on concerns and claims management across the Heath Board. In addition the following actions were completed in 2016/17:

- The Claims Team compiled a Facts Sheet on Redress for people who raise concerns that progress to Redress, to ensure that they understand the Redress process and involved a former complainant in the development of this leaflet.
- The Claims Team compiled a Standard Operating Procedure Manual/Standard Operating Procedures for use within the Department to enhance training of staff

within the Team and continuity in the management of claims, inquests and redress cases.

- The Health Board delivered Well Being sessions for staff within the Patient Feedback Team to assist in coping with the nature of the work that is being dealt with on a daily basis.
- The Claims Team established Peer Reviews to provide support to staff and share complex cases with a view to sharing knowledge, learning and enhancing education and training.
- The Claims Team developed and continue to promote and foster good communication links with the newly developed Directly Managed Units.
- Lawtel has been introduced to assist in the review of case law and quantifying redress claims.
- Introduced BACS payments to reduce costs and streamline the process.
- Introduction pack developed for newly appointed staff.
- Internal Audit on Claims Management confirmed reasonable assurance with no actions identified (green rating).

Actions to be achieved in 2017/18

- Develop and distribute a Handbook on Redress for the Directly Managed Units;
- Inquest training to be provided to the Claims Teams;
- Serious Incident Training to be provided to the Claims Team;
- Action Plan training to be provided to the Claims Team.
- Training on quantifying cases to be provided by Legal & Risk Services to the Claims Team.

11. Inquests

The Health Board provided evidence of a total of 117 inquests during 2016/17. Four of these inquests resulted in the Coroner issuing a Regulation 28 Report, report to help prevent future deaths and promote learning/actions being taken. A summary of the four cases is provided below together with the actions taken to improve patient safety.

ID: 678

The Coroner made a narrative conclusion “the patient died from effect of a bleed, likely to have started at home, likely made worse by what he was taking, possibility of bleed was not taken by supervising medical team until seen by Consultant”.

The Coroner issued a Regulation 28 Report as he was concerned that the issue of sudden onset against background of Warfarin was not given appropriate weight and

concerned that the junior doctor did not escalate up to a senior clinician or make a differential diagnosis. The Coroner noted the action plan implemented by the Health Board and was happy with the actions taken by the Health Board, although felt the need to make a prevention of future death report to serve as a warning to the medical community as a whole. It is not designed against ABMU Health Board but to improve best practice across England and Wales and the report was sent to all Health Boards in Wales.

ID: 649

A multi agency Regulation 28 report was issued marked against Cwm Taf UHB, but also related to ABMU Health Board, WHSSC and Cardiff & Vale UHB. The report related to a lack of an agreed pathway for unconscious STEMI patients requiring PCI in tertiary services.

Following a joint meeting between the Critical Care Network and Cardiac Network on 5 July 2016, it was agreed that the patient was treated correctly but there is a need for an agreed pathway for the unconscious STEMI patients requiring PCI in tertiary services. This includes agreed commissioning funding as current capacity is commissioned for conscious patients with STEMI.

It has been confirmed with the United Hospitals University Bristol Trust that they will take patients in the event there is insufficient critical care capacity in South Wales. The transfer of care will be facilitated by the usual regional PPCI centre both for patients in the South West and the South East of Wales. In addition there is work underway on an all Wales basis to agree a longer term strategy for these patients.

ID: 587

Patient had recurrent falls in hospital, falling admission as a result of a fall at home.

The Coroner issued a Regulation 28 Report as the Coroner had concerns relating to lack of comprehensive handover. The patient was transferred between wards especially in terms of identifying the patient's risk of falls; the accuracy and completeness of nursing notes.

ID: 764

An inquest was held with a narrative conclusion. The Coroner issued a Regulation 28 Report. The Coroner's concerns were that the evidence revealed that there was a poor system in place for requesting additional nursing staff to provide 1:1 support.

Actions taken in response to the Regulation 28 reports include:

- Updated Policy for the Prevention and Management of In-Patient Falls.
- Introduction of a Falls Risk Assessment Tool.
- Introduction of a Post Falls Assessment Checklist.
- Implementation of a Falls Investigation Template and Ward Transfer Document.
- Introduction of weekly meetings with Senior Team in relation to falls and instigation of investigation if a patient has had more than two falls.
- Introduction of Policy for Risk Assessment of Patients requiring 1:1 nursing.
- All staff on the wards have received mandatory Dementia training and all wards have at least one Dementia Champion.
- A Falls Improvement Plan has been implemented which is continually monitored.
- Regular spot checks to monitor documentation.

12. Learning Lessons

12.1 Learning Lessons/Actions Taken relating to Claims

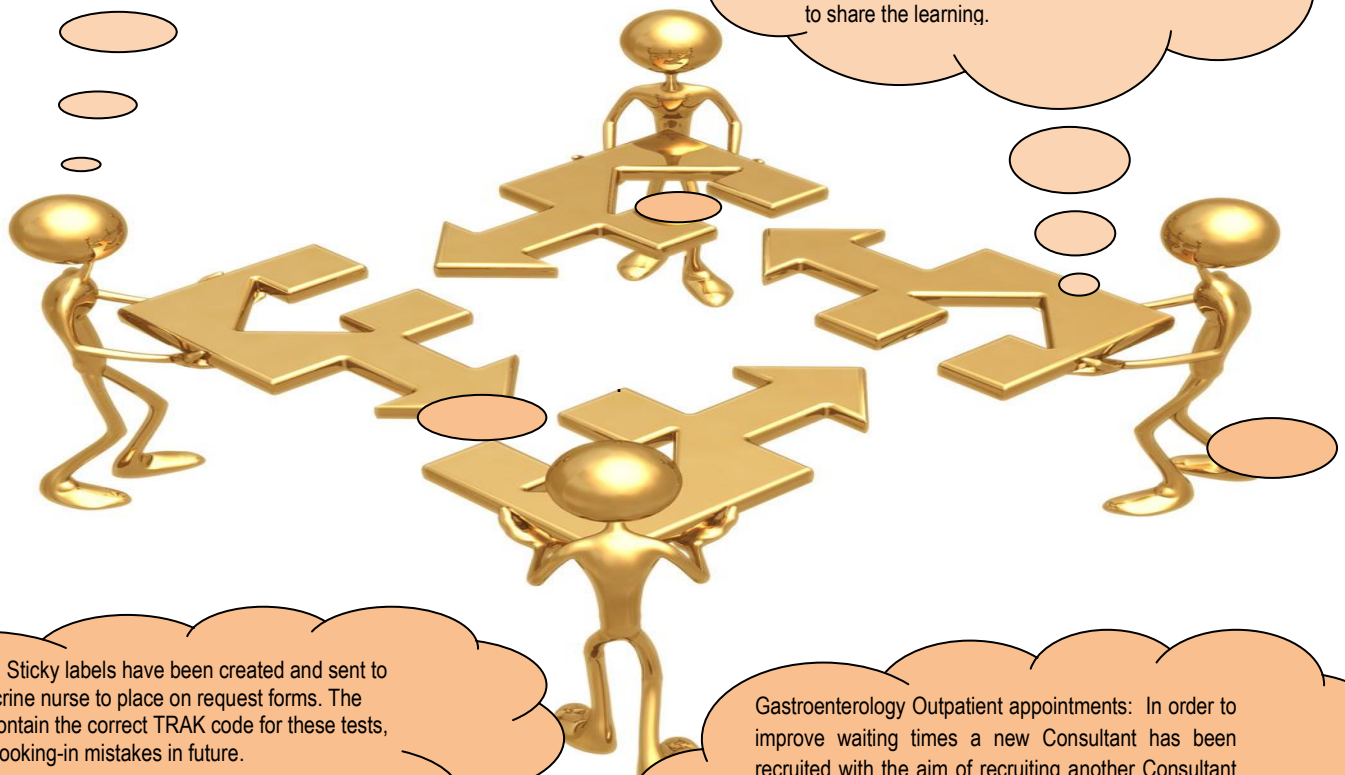
A near miss incident was reported relating to a potential wrong site surgery during a planned procedure.
The process for compiling a theatre list has now been reviewed and changed.
A hand written list is now provided which is transcribed.all compiled theatre lists are now signed-off as accurate by the lead surgeon for the theatre session as complete and accurate.

Grade 3 Pressure Ulcer

Concerns relating to patient developing a Grade 3 Pressure Ulcer - robust action plan developed to address pressure areas across POWH Unit. The action plan includes a more

A review of the use of plastic bags on mental health wards has been undertaken and a benchmarking exercise across other mental health units in the UK carried out.

Following a Serious Incident in a nursing home a training session was provided for the staff concerned by the Diabetic Nurse Specialist, at Singleton Hospital. The Manager of the care home confirmed that the information has been cascaded to all other staff at the Care Home. The Care Home Interface Nurse has been contacted to support similar training for the other Care Homes to share the learning.



Sticky labels have been created and sent to the Endocrine nurse to place on request forms. The stickers contain the correct TRAK code for these tests, to avoid booking-in mistakes in future.

Gastroenterology Outpatient appointments: In order to improve waiting times a new Consultant has been recruited with the aim of recruiting another Consultant within the next few months. Extra clinics are being undertaken and clinical validation of the waiting list in order to further reduce waiting times.

12.2 Complaints Development, Learning and Service Improvement

Complaint Theme	Directorate/Service Delivery Unit		Improvement & Outcome
Car Parking	Hotel Services Morriston		Morriston Hospital management team are working through options which include; • establishment of a task force led by the Executive Director; • additional car parking, in the long term, will be provided with the new development • short term options to both reduce the number of staff cars on site and improve the current space utilisation include promoting bus usage, cycles scheme and car sharing.
Staff attitude	Health Board		Corporate Complaints Trainer has undertaken extensive training in regard of communication with a number of staff. The communication training encompasses values and behavior, dignity, managing aggression and dealing with bereaved relatives. In addition, training is being provided to staff to raise awareness and ensure patients have a 5* experience whilst receiving care within the Health Board. At all training events it is highlighted the importance of receiving feedback from patients to constantly improve the service we are providing.
Waiting times	Health Board		Significant progress was made in 2016/17 in reducing waiting times for our patients. We carried out 3,000 more operations during 2016/17 although these were mainly emergency cases. Therefore the planned care system within ABMU remained relatively unchanged in terms of the number of long waiting patients. In 2016/17 we used a mixture of approaches to seek to improve performance including robust performance management; increased utilisation of a Theatre Admissions Unit at Morriston Hospital; and giving patients the opportunity to be seen at other hospitals. The challenge for 2017/18 will be to ensure a reduction in the number of long waiting patients whilst maintaining the good progress made in reducing outpatient waiting times. Below are some of the immediate actions that we are taking to improve performance: • Meeting weekly with the Service Delivery Units to agree actions to sustain or

			improve their waiting time profiles; • Focusing on unscheduled care flow; • Monitoring theatre performance to challenge clinical practise and maximise capacity; • Developing plans to utilise available theatre space in Singleton hospital for non-complex short-stay surgery cases; • Implementing a modest level of outsourcing with alternative providers; • Considering longer term solutions for supporting our services sustainably; • Undertaking a clinical review of the longest waiting patients; • Implementing any lessons learned arising from the review of waiting list management processes; • Implementation of a 'Local Patient Access Policy'.
Last days of life	Health Board		Improvements have been made to the Datix Web system where we are now able to capture all issues relating to last days of life in complaints. This is then trigured to a Palliative Care Consultant who then undertakes a review of each case and to gauge what the issues are and any recurring themes. This is then fed back to areas and training and discussions undertaken as means of improving the care provided to patients under this category.
Communication/Lack of information for carers	Morriston		Following a complaint involving the Cardiology Department at Morriston Hospital, meetings were arranged with complainant and family members and an improvment plan was formulated which included the compiling of an information leaflet for patients with a specific cardiology condition. This lack of information surrounding this specific condition was identified during the investigation process.
Complaint Theme	**Directorate/Service Delivery Unit**		**Improvement & Outcome**

Joint partnership working with Community Health Council and Health Board staff.	Patient Feedback Team and CHC Staff		To support good working relationships between the CHC and the Health Board a structured meeting programme has been implemented to allow data and trends to be ananlysised and identify ways of sharing information regarding concerns. This meeting structure has been implemented and visits have been arranged for Health Boardf staff who deal with complaints to visit Community Health Care premises as a means of improving working relationships. Regular diaglogue is undertaken with CHC advocates and Health Board staff to establish the progress for complaint investigstions received from the CHC.

Compliments on how investigators and administrative staff have handled a complaint	Corporate Services	Shared learning with other staff
• Compliment received from a complainant. A member of the administrative Patient Feedback Team had taken a verbal complaint via the telephone. The following day the complainant rang to compliment the staff member. The complainant stated that the person had helped to resolve his concerns and he couldn't thank them enough. • Positive feedback received from staff within the Health Board on the training undertaken by the Corporate Complaints Trainer. The training was undertaken in response to a recurring theme of staff attitude in complaints received;- *"Makes you stop and think how you deal with patients on a day to day basis.* *Reminds you to treat everyone with care and dignity at all times. Reminds you to see things from the patient's perspective."* *"Productive, thought provoking and made me reflect on my own practice and my impact on patient/relatives mental wellbeing."* *"Helped me to realise that my actions can cause reactions and to access patients values"*	Patient Feedback Team Patient Feedback Team	Reflective practice with Patient Feedback Team staff.

13. Conclusions

The Health Board continues to make progress in the way concerns and claims are managed and this is evidenced by the reduction in the:

- Reduction in the number of complaints referred to the Public Service Ombudsman in 2016/17;
- Reduction in claims during the year;
- Reduction in the number of complaints upheld linked to poor complaints handling.

However, we recognise that further work is required to continue to embed the changes made, ensure consistency across the six Service Delivery Units and focus on continuous improvement and embed the learning.

A number of actions have been identified within the report to improve the management of concerns and claims within the Health Board. These actions underpin the main objective of the Patient Feedback Team which is to deal with concerns timely and conduct robust investigations which produce recommendations, actions taken and the lessons learned shared across the Health Board to reduce the likelihood of harm to patients.

Appendix 1

Definitions

CLAIM	Legal perusal of action against a party to compensate for losses incurred.
CONCERN	A complaint, a notification of an incident concerning patient safety or a claim for compensation.
COMPLAINT	Any expression of dissatisfaction.
INCIDENT	Any unexpected or unintended incident, which did lead, or could have led to harm for a patient.
NON-OFFICER MEMEBER	A member of the Board who is not an employee of the Health Board.
OFFICER MEMBER	A member of the Board who is an employee of the Health Board.
PATIENT	The person who received or has received services from the Health Board.
PUBLIC SERVICES OMBUDSMAN FOR WALES	If a person raising a concern remains dissatisfied after raising a concern with a Health Board, they can request an independent review by the Public Services Ombudsman for Wales (PSOW).
PUTTING THINGS RIGHT	Guidance produced by Welsh Government for the NHS in Wales to enable health organisations to handle concerns in accordance with the NHS Redress Regulations.
REDRESS	Redress relates to situations where the patient may have been harmed and that harm was caused by the NHS in Wales. Redress can comprise of: ▪ a written apology; ▪ a report on the action which has or will be taken to prevent similar concerns arising; ▪ the giving of an explanation, and ▪ the offer of financial compensation and/or remedial treatment, on the proviso that the person will not seek to pursue the same through legal action.
QUALIFYING LIABILITY	Where a Welsh NHS body has BOTH (1) failed in its duty of care to a patient, and that the breach of duty of care has been (2) causative of the harm that the person has suffered. It is only when both these tests are satisfied that a payment of compensation under the NHS Redress Regulations should be considered.