Putting Things Right Annual Report 2019-2020

Concerns (Complaints, Claims and Patient Safety Incidents and Service User and Patient Experience)

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Introduction

Betsi Cadwaladr Health Board recognises that patient safety and experience, public engagement and involvement is a vital aspect of the Health Board's governance arrangements. The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (the Regulations) came into force on 1st April 2011, to enable Responsible Bodies to effectively handle concerns.

The regulation is in place to streamline the handling of concerns and under the '*Putting Things Right*' (PTR) arrangements, all NHS Wales organisations should aim to "investigate once, investigate well", ensuring that concerns are dealt with in the right way, the first time around. The term "Concern" relates to any complaint, claim or reported patient/service user safety incident about NHS treatment or service.

This means, that whenever concerns are raised about treatment and care, whether through a complaint, claim or patient safety incident, those involved can expect to receive a prompt acknowledgement and response, about how the matter will be taken forward, dealt with openly and honestly and have an appropriate investigation undertaken into the concerns raised. All concerns are logged into the Health Board NHS Datix Risk Management system.

Patient safety is paramount and is focused on the prevention of harm to patients by improving the way in which care is delivered so that errors are prevented, learning occurs from the errors that do occur. A culture of patient safety is fostered, that involves health care professionals, partner organisations, patients, carers, families and the general public.

This annual report has been prepared in line with the PTR Regulations to provide an overview of the 2019/2020 position in terms of how the Health Board has managed concerns during this time. It provides an overview of themes and trends emerging from Concerns including some of the lessons learned.

In October 2019, we were very pleased to welcome our new Assistant Director of Patient Safety and Experience who has brought a wealth of knowledge and experience to support our commitment to patient safety and experience.

Formal Complaints:

1866

Response times

Acknowledged 2 working days: 94%

30 working days response: 47%

OTS Complaints (Informal):

3294

Compliments:

784

Putting Things Right Overview of 2019/2020

Redress Cases:

80

New Claims:

307

Incidents:

35628

Never Events:

6

Looking Back: Learning and Achievements

Learning & Achievements over 2019/20

During 2019/20, we initiated a complete review of patient feedback and complaints processes to achieve improved outcomes in the management of concerns, including PTR timescales for responses, as this was a challenge for the Health Board throughout the financial year. This significant work includes the implementation of the Patient Advise and Liaison service (PALs), on all three main hospital sites. This service provides support, advice and resolution to patients with awareness of the service raised amongst staff and members of the public across all our hospital sites.

The review has also resulted in an ongoing restructure of the Patient Safety and Experience Department that supports our commitment to meet the PTR regulations requirements.

A rapid review process for all serious incidents was introduced that has improved immediate learning from complaints and incidents that sets in motion the investigation process in a timelier manner.

Service Users feedback has been received during the year via 'Viewpoint' our real time feedback system. Staff use this feedback to support service improvement, ward accreditation (NHS quality based patient safety approval scheme) and quality assurance evidence. Comment cards and monthly patient questionnaires provide a variety of ways for patients (inpatient, outpatients, community and primary care), families and members of the public to feedback their experiences, whether positive or negative.

A Learning from Events Redress process has been introduced to ensure that lessons learned from serious incidents and complaints are used to provide assurance and evidence of changes to clinical practice.

The Health Board approved its current Patient Experience Strategy in June 2019 that can be accessed via our web site (the link can be found in our useful information section on page 34). The strategy is planned for a refresh in December 2020 to capture learning from the first year of implementation and to consider integration of wider issues such as carer engagement, involvement and support.

Complaints

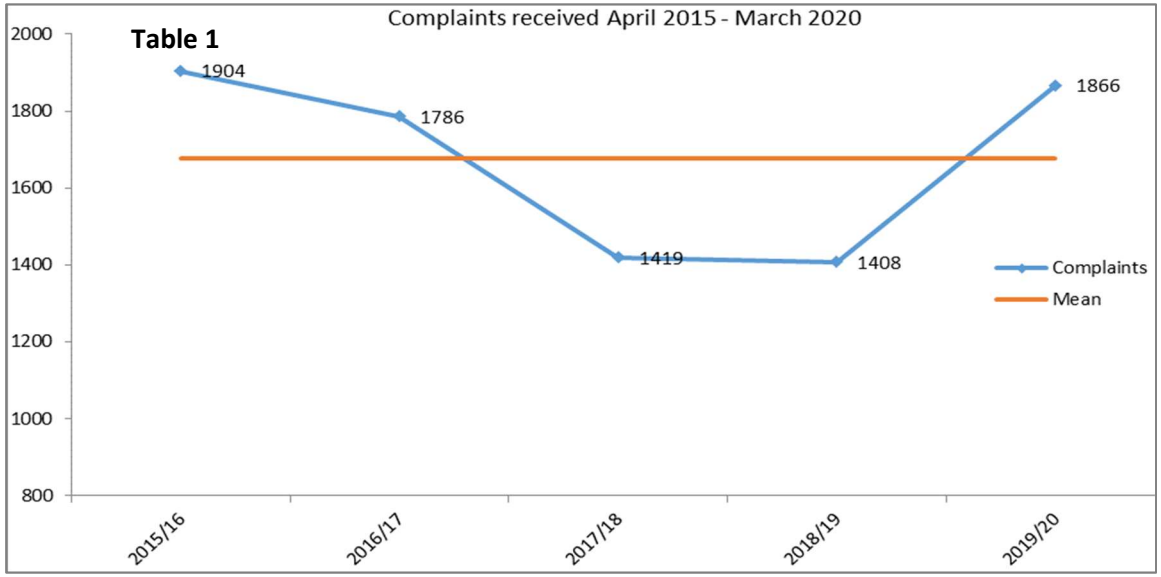
All complaints received by the Health Board are managed in accordance with NHS Concerns, Complaints and Redress Arrangement (Wales) Regulation 2011. The range of complaints received by the Health Board are diverse, complex, and sometimes overlap a number of services, therefore, to assist in the most appropriate investigation an individual raising a complaint may be invited to discuss this with a member of the Patient Experience Team. This not only provides a deeper understanding of the questions that complainants have, it also enables the patient experience team to facilitate either a local resolution, or manage and support the complaint through the formal complaint PTR procedure.

The Patient Safety and Experience Department is currently undertaking a comprehensive review of the complaints strategy and operational management of complaints. This has included the three main hospitals and community sites through workshops with the teams. Workshops were held with a range of partner agencies, including amongst others Community Health Councils (CHC) and the Public Service Ombudsman for Wales (PSOW). The outcomes and feedback from the consultation are being used to develop a new Complaints process that will be implemented early in 2021.

Complaints activity

The reporting period from 1st April 2019 to March 31st 2020 saw a rise in the number of complaints received, up from 1408 to 1866. The increase in complaints reflects, in part the improvements in the accessibility of complaint reporting via the Health Board website and training staff to encourage service users to provide feedback about their experience. The Health Board views complaints as a valuable opportunity for services to learn and make continuous service improvements. Furthermore, this upward trend of reporting is reflected by clinical staff, increasingly signposting service users to the complaints team and responding to on the spot (OTS) 'early resolution' complaints. This has the benefit of ensuring that service users concerns are actively managed with learning outcomes and changes to practice tracked.

Table 1 illustrates the rise in complaints received over a five-year period. The Health Board acknowledges that the **1822** complaints received during **2019/20** is above the annual average, this is in contrast to 2017/2018 and 2018/2019 figures. This could be attributable to an increase in the number of complaints about Clinical Assessment and Treatment, however there are no apparent specific trends or themes within this increase.



On the Spot (OTS) 'Early Resolution' Complaints

On the spot 'early resolution' are complaints that are required to be resolved within 48 hours and if not are upgraded to a formal complaint. The numbers have risen in the period for 1st March 2019 – 31st March 2020, from **2985** to **3294**.

This data is useful in that it allows training to target those identified areas, an example being customer care. However, whilst the range of complaints within those categories are too diverse to be outlined within this report, themes and trends within areas are recognised and escalated in real time to the Heads of Services.

Themes of OTS complaints include providing and facilitating information sharing for service users, resolving communication breakdown, signposting and directions to relevant services, facilitating involvement in care and supporting improved communication between service users and BCUHB staff.

There is also a requirement that learning is demonstrated in response to each individual complaint. The maintenance and audit of improvement will also be an area, which the new complaints process will focus on. The increase in OTS complaints may be attributable to more accurate recording of OTS complaints in clinical environments.

Facilitating OTS's resolution has further improved the working relationship with services supporting the early resolution of a complaint rather than resulting in a formal complaint.

The percentage of early resolution complaints that were upgraded to a formal complaint was **12.8%,** may be due to the complainant remaining dissatisfied, or the timescale of resolution 48 hours not being met. Early resolution complaint management processes will be included in the new complaints procedure, as not meeting timescales resulting in complaint responses, is neither beneficial to the complainant nor the service.

Formal complaints performance Table 2

Table 2 : Formal Complaints Key Performance Indicators	2015/16	2016/17	2017/18	2018/19	2019/20
Total Number of Formal Complaints	1904	1786	1419	1408	1866
No of complaints acknowledged within 2 working days	1453 (76%)	1544 (86%)	1298 (92%)	1307 (93%)	1749 (94%)
No of complaints responded to within 30 working days of receipt	449 (24%)	552 (31%)	487 (34%)	482 (34%)	885 (47%)
No of complaints responded to within a period exceeding 30 working days but within 6 months	1079 (57%)	1064 (60%)	846 (60%)	826 (59%)	876 (47%)

The comparative performance of the PTR Key Performance Indicators is outlined in table two. There is a slight increase of concerns being acknowledged within two working days up to **94%**, set against a target of **95%**. There is also a significant increase in the number of complaints being responded to within thirty days of receipt, up from **34%** to **47%**. It is acknowledged, that whilst this is below target, which is set at **75%**, it is an upward trend of improvement that is a result of the work that has been put into responding to complaints in a timely manner

The final performance indicator outlines the number of concerns responded to within a period exceeding thirty days, but within six months. This has fallen from **59%** to **47%**, which whilst disappointing, may reflect the complexity of a complaint, and the wide range of professionals

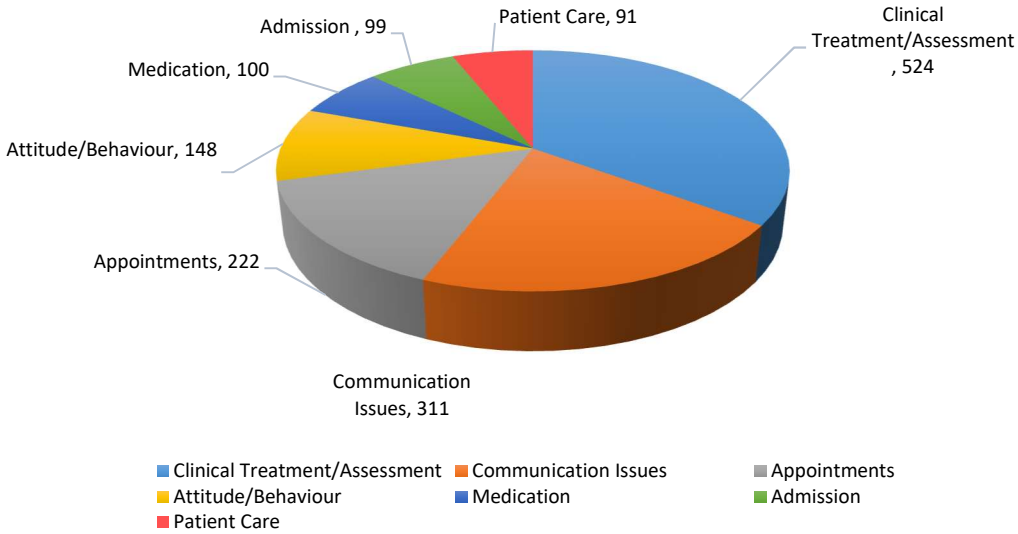
involved in the complaint. This decrease in performance has been acknowledged by the Patient Experience Team and the reasons will be investigated with a view to improvement as part of the overall review of the complaints processes.

Complaints Categories

Table 3 indicates complaints received over the period March 31st 2019 – 1st April 2020 by theme. The main reason for complaints is about clinical treatment/assessment.

This information enables the organisation to analyse the causes, trends and themes of complaints for our patients, service users and members of the public. The analyses is also used to learn from complaints and inform improvements in our services as well as training for our staff. In response to the main reasons for complaints i.e. clinical treatment /assessment, appointments, attitude and behaviour, the learning that has resulted includes:

Table 3 Formal Complaints by Theme



- The importance of clear communication with patients and families
- Staff reflections about perceived attitude and behaviour
- Building service capacity to improve appointment waiting times

Public Service Ombudsman for Wales

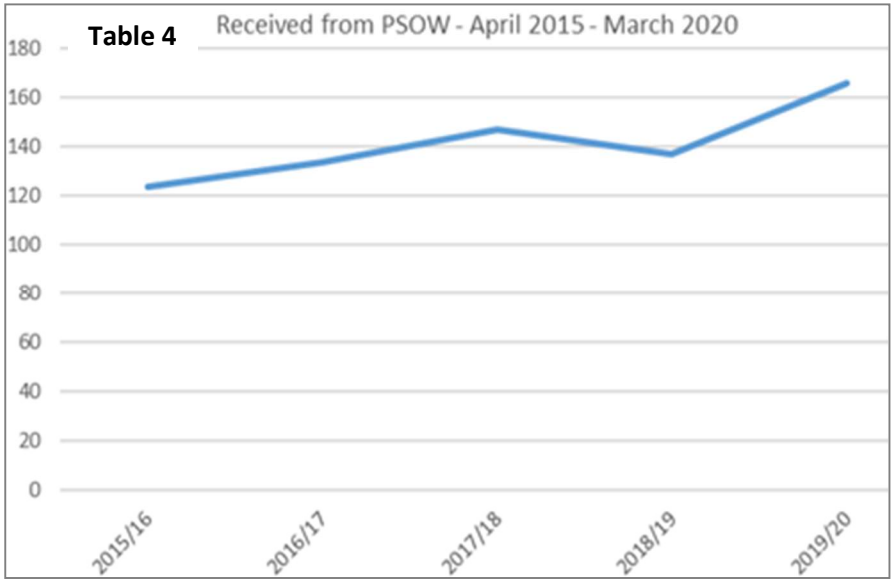
If a complainant is not satisfied by the Health Boards response to their complaint, they can ask the Public Service Ombudsman Wales (PSOW) to undertake a further independent investigation. As shown in **Table 4** in 2019/20, **166** complainants made the decision to approach the Ombudsman.

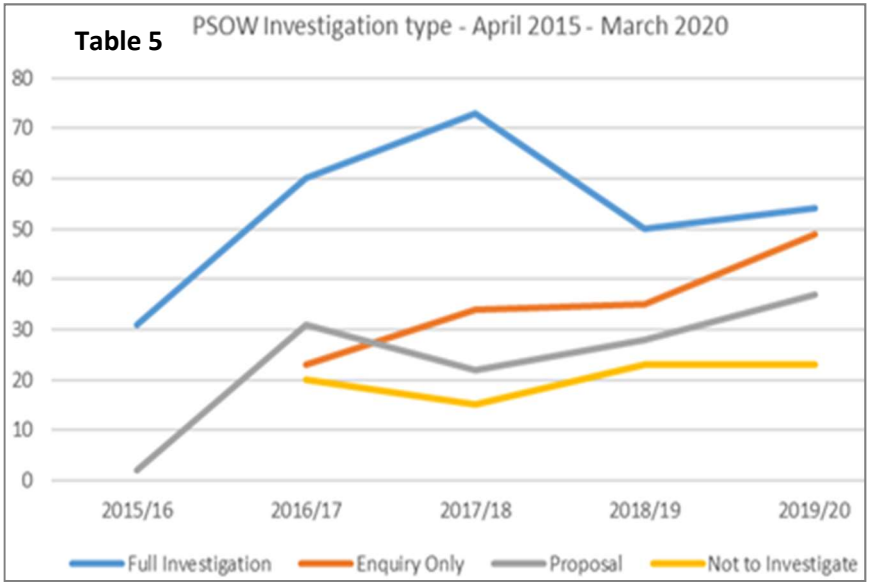
Of those **166** cases, the Ombudsman decided to fully investigate **54** cases, **49** enquiries were received where the Health Board were requested to provide PSOW with information, **26** cases were not investigated by the Ombudsman. This is usually because the complaint was submitted out of time, the complainant was requesting financial compensation, or the Heath Board had not had an opportunity to respond before the complainant approached the Ombudsman. **37** cases were dealt with as a Proposal where the Health Board agreed to carry out specific actions in order to resolve outstanding issues. These figures are illustrates in **Table 5.**

These figures are higher than 2018/19, when **137** people approached the Ombudsman who decided to investigate 49 cases. During 2017/18, **146** people reported their case to the Ombudsman with **70** cases being investigated.

The PSOW advises that a complaint, which relates to one specific issue, and substantive evidence is found to support the allegation made**,** the complaint is recorded as 'upheld'. If a complaint is made regarding more than one issue, and one or more of these issues are upheld, the complaint is recorded as 'partially upheld'**.**

Of the **54** cases investigated during 2019/20, 5 have been either fully or partially upheld and **6** were not upheld. Information on the remaining **32** cases has not yet been received from the Ombudsman's who continue with their investigations.





Further details of the cases reviewed by the Ombudsman will be available online in the Public Service Ombudsman for Wales Annual Report at: https://www.ombudsman.wales/annual-report-accounts/

The following themes have been identified from the ombudsman cases during 2019/2020:

1. Delays – with clinical assessments and treatment
2. Maladministration i.e. poor complaint handling and poor investigation of complaints
3. Poor standard of clinical care and treatment provided

Learning from Ombudsman cases

For each case where the Ombudsman has fully investigated a complaint, a Lessons Learned Report is prepared for consideration by the Patient and Carer Experience (PCE) Group as well as division specific Clinical Governance Team meetings.

Each PSOW report highlights what happened, what the Ombudsman found during his investigation and what actions were taken following what the Health Board learned which identifies how issues have been addressed to reduce the risk of recurrence.

In each case where the Ombudsman upholds the complaint, recommendations will be made for the Health Board to implement. The Ombudsman will not close a case until the Health Board has provided documentary evidence of compliance to support each recommendation.

To satisfy themselves that measures have been put in place to ensure the same failings do not happen again, Clinical Governance Teams within Divisions present their lessons learned documents for discussion and learning.

Public Interest Section 16 and Section 21 Reports

The PSOW does not routinely publish his reports and under the PSO (Wales) Act 2005, the Ombudsman can issue one of two types of reports. These reports are issued following an investigation into a complaint by a member of the public that they have suffered hardship or injustice through maladministration or service failure on the part of a public body. The first type of report is known as a Section 16 report is issued when the Ombudsman believes that the investigation report contains matters of public interest. The body concerned is obliged to give publicity to such a report within its own financial expense.

The second type of report that the Ombudsman can issue is known as a **Section 21** report. He can do so if the public body concerned has agreed to implement any recommendations he has made and if he is satisfied that there is no public interest involved.

BCUHB received two public interest **Section 16** reports during 2019/20 when the Ombudsman found serious failings, which included communication between the Health Board and a Local Council. The other Section 16 report was reconsidered and retracted by the Ombudsman who subsequently issued as a non-public interest Section 21 Report.

Expanded Ombudsman Powers

Changes to the Ombudsman jurisdiction came into effect from 23 July 2019, following the implementation of the Public Services Ombudsman

Wales Act 2019. The Ombudsman can now consider complaints where a private healthcare provider has entered into contract arrangements with NHS Health Boards to deliver services is now able to investigate a complaint about the clinical care.

Under the PSOW Act, the Ombudsman is also able to conduct his own initiative investigations, which can extend an investigation to include consideration of actions by a body not already complained about. The Health Board to date have not been involved in any investigations by the Ombudsman using the new powers.

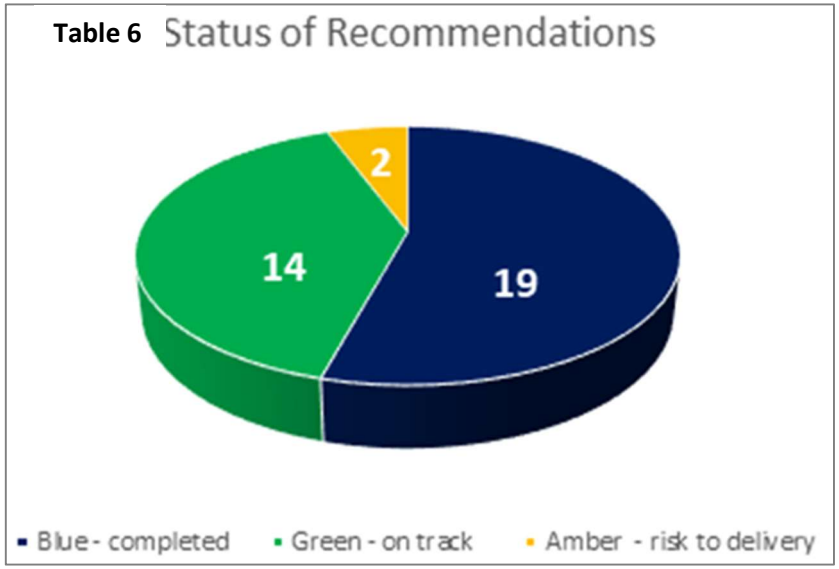
HASCAS & Ockenden Improvement Work

In September 2015, the Health Board commissioned HASCAS Consultancy Limited (now Duncan & Johnstone Limited) to lead an independent investigation in relation to the complaints, concerns and professional regulation and employment issues arising from the serious concerns raised about care on Tawel Fan ward.

HASCAS published the Lessons for Learning Report on 3 May 2018, which provided the Health Board with a full, evidence-based view that is the result of a comprehensive investigative process, which included over 100 interviews with families and staff. The Ockenden Review of Governance Arrangements published in July 2018 provided an independent governance review relating to Tawel Fan ward, prior to closure and current governance arrangements in older people's mental health. The Health Board accepted the recommendations and a Task force comprising of Gill Harris, Executive Director of Nursing and Midwifery, established an Improvement Group and a Stakeholder Group in August 2018.

The Stakeholder Group meets on a quarterly basis and Stakeholder members have engaged directly with operational leads and respective working groups established for some of the recommendations, which have made valuable contribution to the work of some of the recommendations. The Stakeholder Group has also received presentations from operational leads on a number of the recommendations to provide detailed progress updates.

Table 6 Status of Recommendations



Progress against recommendations Table 6

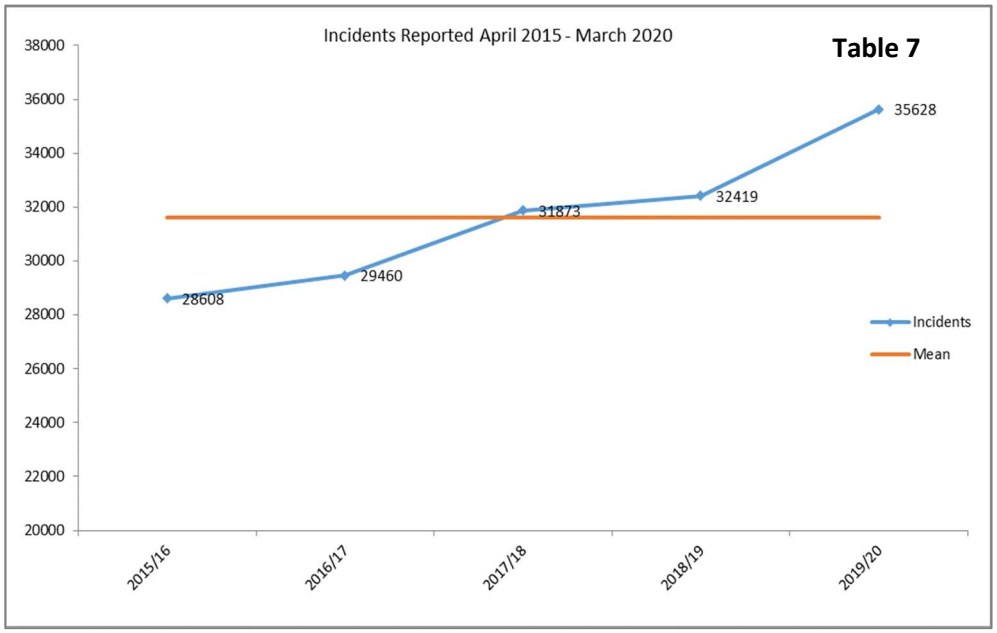
Progress has been made for the **35** HASCAS and Ockenden recommendations;

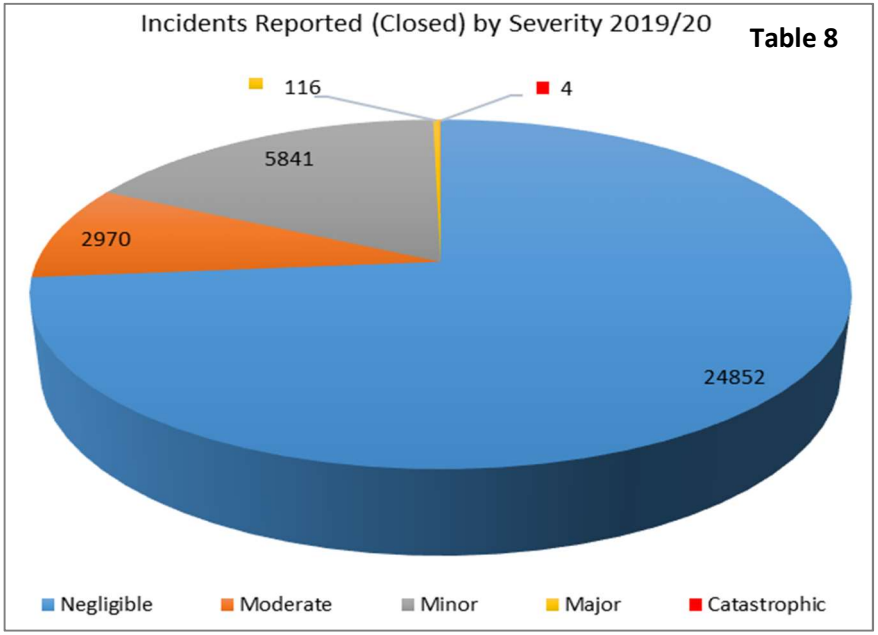
- **19** now having been signed off as fully implemented
- Out of the **16** that remain open **14** are on track to deliver, **2** are in progress which require some additional focus or support to address some challenges.

Progress updates are reported to the Quality Safety and Experience Committee bi-monthly and to the Board quarterly for scrutiny and quality assurance.

Incidents

Patient safety incidents are any unintended or unexpected incidents, which could have, or did, lead to harm for one or more patients receiving healthcare. Incidents are reported on Datix, the reporting. Incidents are reviewed at site and area level via their respective Quality and Safety sub groups. In addition, management of incidents are scrutinised and monitored at a monthly Quality and Safety Group which is chaired by the Executive Director of Nursing.





A run chart, is a graph that displays data in a time sequence. The run chart in Table 7 illustrates an increase in incident reporting year on year. The Health Board actively encourages all staff to report any patient safety incident including those categorised as near misses. Incident reporting is considered to be one of the mechanisms that the Health Board utilises to gain learning and drive improvements.

The pie chart in Table 8 illustrates the number of incidents reported by the NHS incident classification of negligible, moderate, minor, major and catastrophic for the year 2019/2020.

Table 8 also illustrates incidents that have been closed following investigation and illustrates that the majority of incidents reported are classed as negligible (no harm) incidents or minor (low harm) incidents. Any incidents that have caused significant harm are also reported to the Welsh Government and are managed via the organisation's serious incident process.

The themes from reported incidents includes pressure sores found on admission and slips, trips and falls. Actions to address these incidents include:

- Implementation of a new process for investigating patient pressure cores identified on admission to acute or community hospitals
- Falls that have caused harm are most commonly linked to care of the elderly and older person's mental health and an enhanced immediate review of the patient falls plan has been introduced.

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Never Events

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers. The Welsh Government issues a list of serious incidents that are deemed Never Events. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event. Never Events require a full investigation under the Serious Incident Framework.

Since April 2010, all serious incident notifications have been reported electronically to the Improving Patient Safety Team Mailbox at the Welsh Government. This should be completed within 24 hours of the incident. The Welsh Government respond within 24 hours and set-out a grade of the incident.

During the period 1 April 2019 to 31 March 2020, a total of **6** Never Events were reported to Welsh Government; **4** Never Events have been closed and **2** remain open as they are subject to ongoing investigation.

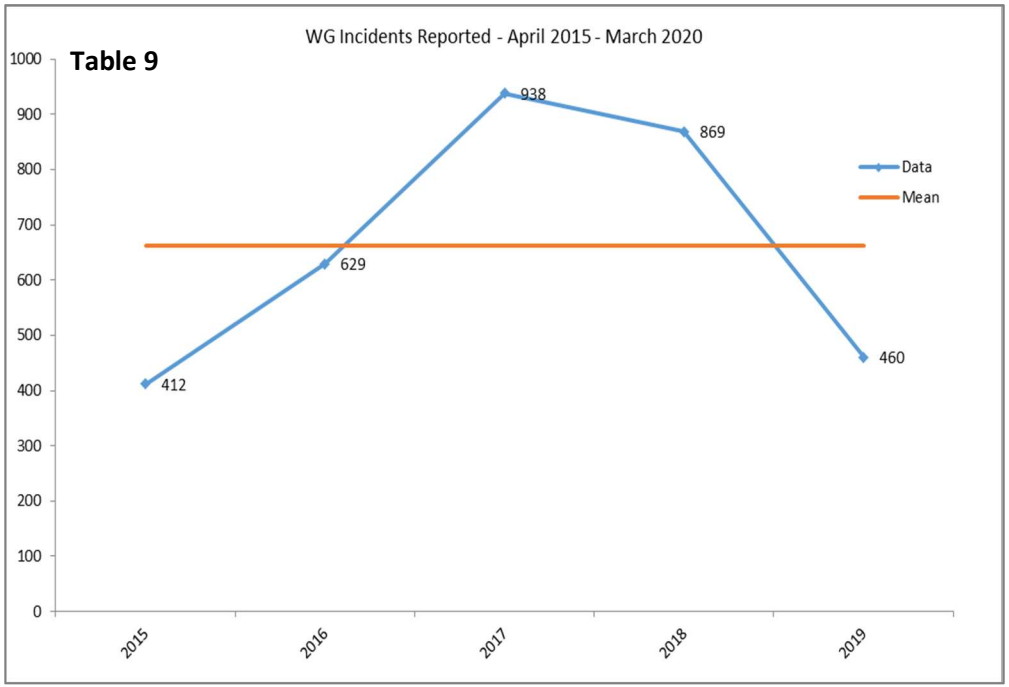
The key learning points from these completed investigations are set below.

- Peripherally inserted central catheter (PIC) line (a long thin tube that is usually inserted through a vein in the arm and passed through to the larger veins near the heart), should only be inserted if no alternative is available and a register of PICC line insertions is now held.
- Out of Hours patients are transferred to Intensive Care Unit (ITU) for PICC line commencement
- Visual prompts to ‘stop before you block’ added to Theatre trollies and World Health Organisation checklist training update has been completed including Stop Before You Block. An updated Induction form for all new or visiting Theatre staff to include ‘stop before you block’ to raise awareness is now in place. (Stop before you Block is a standard process that checks and confirms the patient identity, consent form and marking of the correct surgical site for the planned procedure).
- Importance of second consent check for a procedure emphasised to all relevant staff.

Welsh Government Reportable Incidents

Welsh NHS bodies are required to report all serious patient safety incidents to the Improving Patient Safety Team of the Welsh Government (WG) within 24 hours of the incident.

Table 9 illustrates that for the period 2019/2020, there has been a total of **460** serious incidents reported to the Welsh Government. This is a **47%** reduction compared with the previous period 2018/2019. The reporting has reduced over the year and is currently under review.



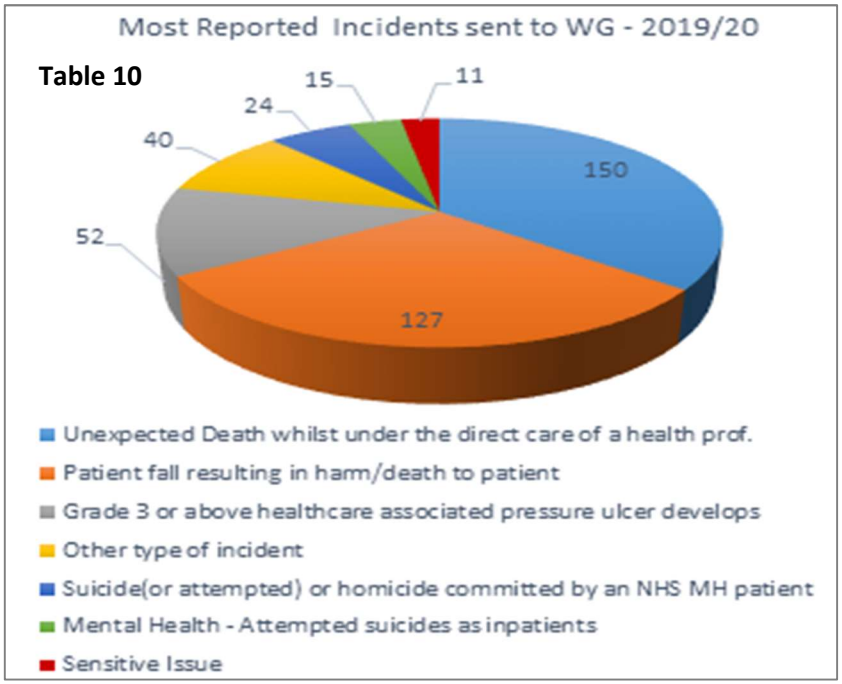


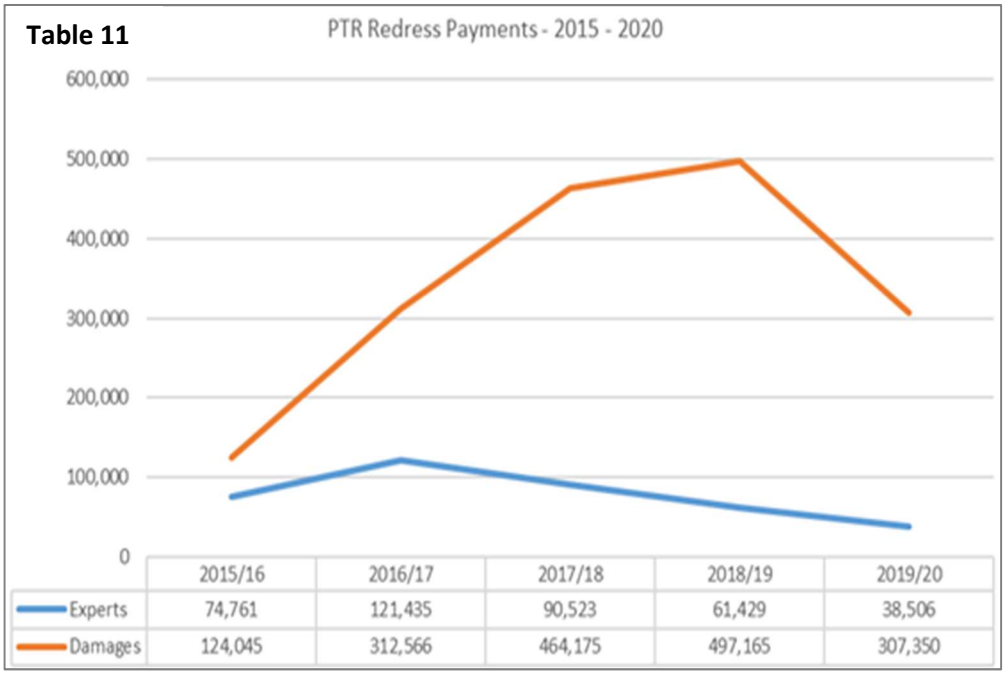
Table 10 illustrates the types of incidents reported to Welsh Government with learning from these incidents include. The unexpected death of a patient whilst under the direct care of a professional is the most reported incident to Welsh Government. This can be attributed to Welsh Government changes to reporting criteria for the Mental Health and Learning Disabilities Division, who are now required to report all unexpected deaths open to their services. The learning from incidents has included further improving communications between teams to ensure that all patient contacts across the Mental Health and Disabilities Division are documented in the Mental Health Medical Record.

Redress

Whenever a complaint is received or incident reported that contains an allegation of harm, the Health Board has a duty to consider the likelihood of any qualifying liability in tort arising. Whilst the Health Board always strives to ensure it delivers the best possible care and treatment, sometimes things may not go as well as expected. When that happens, there are Regulations which, the Health Board must follow to consider whether what has gone wrong has caused the patient any harm. If it has, we have a duty to try to make it better. This is called Redress, and can include one or more of the following:

- a full explanation of what happened
- an apology
- an offer to provide care or treatment (where appropriate)
- a report on action which has been, or will be taken to prevent similar cases arising
- and/or financial compensation (maximum £25,000).

Table 11



	2015/16	2016/17	2017/18	2018/19	2019/20
Experts	74,761	121,435	90,523	61,429	38,506
Damages	124,045	312,566	464,175	497,165	307,350

PTR Redress payments peaked in 2018/19 as a number of historical high value cases were settled (**Table 11**).

The cost of instructing external clinical experts is continuing to decrease as Health Board senior clinicians have become fully involved in the investigation of a complaint or incident and the redress process.

The Health Board concluded **80** cases under the Putting Things Right (PTR) Redress Regulations in 2019/20 compared to **94** during 2018/19. The outcome of the 80 cases was

- 38 financial compensation
- 8 apology letters
- 24 cases which became clinical negligence claims
- 10 concerns where it was considered the financial redress allowed under PTR would be exceeded. For these cases a response was sent, advising the complainant to seek legal advice about pursuing a clinical negligence claim and explaining that if a qualifying liability were found to exist, it would not be appropriate to make an offer of redress under the Putting Things Right Redress Regulations, as the amount of compensation may exceed £25,000.

Themes and Trends

The following themes have been identified from the redress cases during 2019/2020:

1. Delays – with clinical assessments and treatment
2. Patient falls
3. Poor standard of clinical treatment

Learning from Redress cases

The Welsh Risk Pool (WRP) is part of the NHS Shared Service Partnership Legal and Risk service. It provides the means by which all Health Boards in Wales are able to insure against risk. The role of the WRP is to have an integrated approach towards risk assessment**,** claims management**,** reimbursement and learning to improve**.**

For each redress case a Learning from Events Report is prepared for consideration by the WRP to report the issues that have been identified and how they have been addressed to reduce the risk of recurrence.

Examples of learning from the redress cases concluded within 2019/20 are as follows:

- **Sepsis was not dealt with quickly enough and antibiotics should have been administered sooner:**
  Work has been undertaken, led by the Office of the Medical Director, to improve the knowledge and practice of both nursing and medical staff in relation to sepsis.

- **Name and address label sheet was placed into the back of the wrong patient's clinical notes:**
  Following this incident staff have been reminded of the importance of checking personal data to ensure that it is correct for that patient. The Health Records team have also reminded staff of the importance of checking patient data when setting up case notes and preparing them for clinic.

- **Delay in the Emergency Department the patient was not reviewed by a doctor until an unfortunate fall:**
  A new Emergency Department policy and documentation has been developed that incorporates falls assessment, frailty score and risk assessment for pressure ulcers.

- **Failure to identify a tumour on a scan which lead to delay in diagnosis:**
  Scan images were reviewed at the Radiology learning meeting to share the learning. The pathology department have added an additional checking process to ensure requests for tests are made, and followed up, in a timely way.

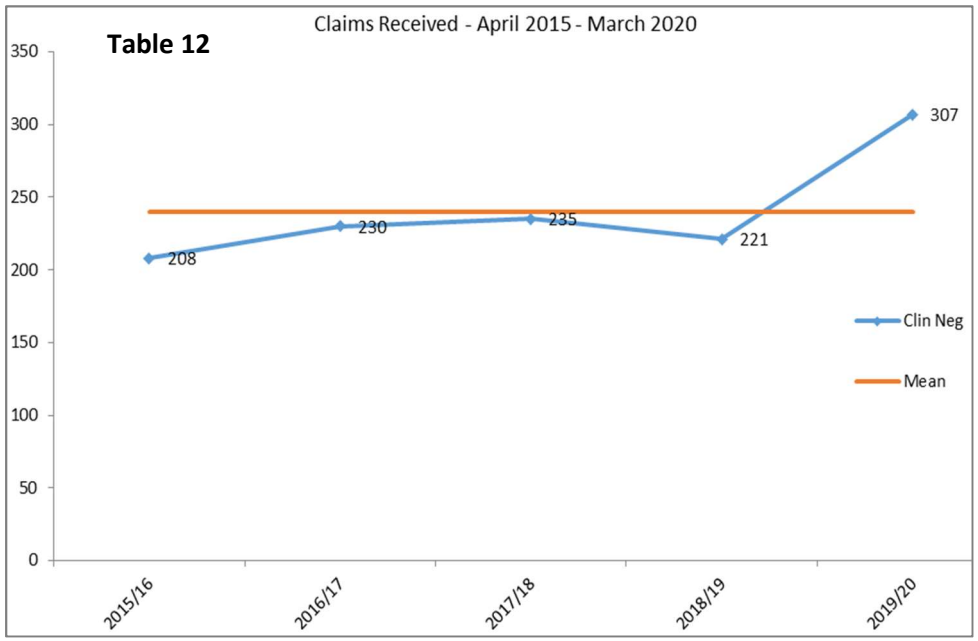
- **Incorrect advice given over the telephone to patient with history of diarrhoea review of a patient's medical history and the medication list, which included diuretics (water tablets):**
  The Health Board issued a revised and re-dated Acute Kidney Injury (AKI) guidance leaflet to all Healthcare Professionals in North Wales for patients with AKI or those who are considered to be at risk of AKI and the action to be taken in such situations.

Claims

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

- Clinical/medical negligence claims
- Personal injury claims

Clinical Negligence and Personal Injury claims are managed by the Health Board on the basis of legal advice provided by NHS Wales Shared Services Partnership Legal and Risk Services. The Welsh Risk Pool (WRP) will reimburse the Health Board for all losses incurred on a case-by-case basis, if the Health Board can evidence learning. As shown in Tables **12 and 13,** there have been a total of **356** new claims opened for the period 1st April 2019 - 31st March 2020.

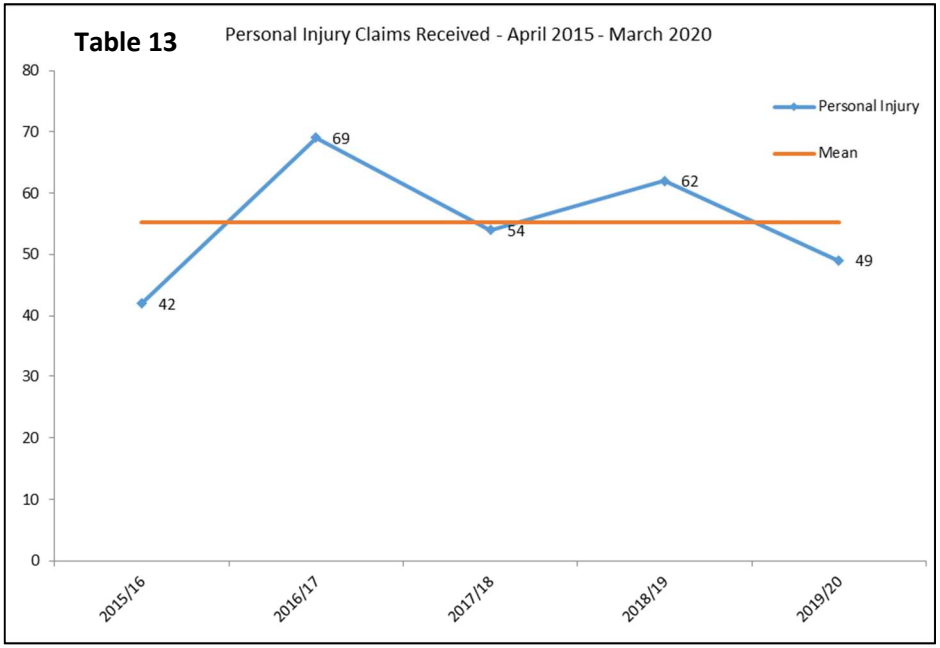


Of the new claims opened **307 (Table 12)** were Clinical Negligence and **49** (**Table 13**) were Personal Injury claims. Of the 307 Clinical Negligence claims, the following themes have been identified during 2019/2020:

1. Implementation of care
2. Diagnosis – Including delay in diagnosis
3. Treatment or procedure

The largest number of open claims related to Surgery, Specialist Medicine, Women and Maternal Care. This is expected, and not unusual due to the higher risk profiles of some NHS specialities. There is also a number of cases categorised as 'no value', which relate to Disclosure Requests/Pending Claims that the Claims Team have been unable to categorise due to the limited information provided by the Claimant Solicitors.

Table 13 Personal Injury Claims Received - April 2015 - March 2020



Of the **49** Personal Injury claims, the following themes have been identified during 2019/2020, with a rise in the numbers of claims relating to the following:

1. Data Breach
2. Occupational Stress
3. Needle stick

Other categories remain steady with the exception of lifting which has decreased.

Open Claims

There has been an increase in the number of claims received by the Health Board in 2019/20 following the introduction of General Data Protection Regulation (GDPR) allowing Claimant Solicitor Firms to gain access to copy records without having to pay a fee when investigating potential claims. Claimant Solicitors can now request copy records without having to pay a fee, which has led to an increase in the number of firms requesting records to investigate potential claims.

Learning

Revised WRP Case Reimbursement Procedures came into effect on 1st October 2019. The procedures were revised to align the various schemes that WRP administer reimbursement of and to ensure the introduction of earlier scrutiny of learning to 60 working days from decision to settle a case in an endeavour to reduce the risk of recurrence.

The new WRP procedures introduce a Learning from Events Report (LfER) and a Case Management Report (CMR). These are used by the Health Board to report the issues that have been identified from a claim and to determine how these have been addressed in order to reduce the risk of reoccurrence and reduce the impact of a future event. The trigger for an LfER is related to the date of a decision to settle a case (even if the loss incurred is under £25,000) and the Health Board has sixty working days to submit a report from this date. A CMR is then submitted four months after the last payment on a claim is made, detailing how quantum was decided, if delegated authority was used and confirming that senior leaders have been advised of the claims. The LfER needs to provide a sufficient explanation of the circumstances and background to the events, which have led to the case, in order for the WRP Committee to scrutinise and identify the links to the findings and learning outcomes. Supporting information, such as action plans, expert reports and review findings can be appended to the LfER to evidence the learning activity.

Claims Audit

A review of compliance with the WRP Claims Management Standard was undertaken in accordance with the 2019/20 Internal Audit Plan. The systems and controls in place were reviewed and assurance was sought against Assessment Area **10** of the Welsh Risk Management Concerns and Compensation Claims Standard.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with WRP Claims Management Standard was 'reasonable assurance'.

Changes to Datix have been implemented by the Claims Managers, which include new fields to monitor progress of LfER reports and the different stages of approval and reimbursement from WRP. This will assist in ensuring learning is captured and evidenced to improve patient care for the future.

Claims Governance Procedure

The Executive Team for the Health Board now have an enhanced view in the financial approval of claims. A report of cases where authority has been provided to agree liability and settle damages and costs has also been put in place and is sent to the Associate Director of Quality Assurance

on a monthly basis. The Audit Committee also now receive a report on all claims settled over £50,000. This report is has strengthened the Claims Governance procedures.

Inquests

There are many reasons why the Coroner may hold an inquest when someone dies and the Health Board will provide evidence as requested by the Coroner. The Health Board engages with the North Wales Coroners and their officers in relation to supporting the Inquest Process and in response to information requests and the Head of Patient Safety is the main Health Board point of contact for the Coroners. A standard operating procedure has been introduced across all three acute sites across the Health Board, to ensure a unified approach to assisting H M Coroner with their enquiries.

Table 14 illustrates the total Inquests received for the period 2019/20; **287** inquests were held in relation to patients under the care of the Health Board for the reportable period.

Table 14	Central	East	West	Total
Acute	81	67	18	166
Mental Health	40	63	18	121
Total	**121**	**130**	**36**	**287**

Coroner's Regulation 28 Reports

The Coroner has a statutory duty to issue a report to any person or organisation where it is their opinion that action should be taken to prevent future deaths in similar circumstance. These are known as "Reports on actions to prevent future deaths – Regulation 28"

The Health Board has been issued with **2** regulation 28 reports during 2019/20, which are sent directly to the Chief Executive for action. Each of these requires a formal response from the Health Board within 56 days outlining actions taken by the Clinical teams and managers to assure the Coroner that all areas of concern have been resolved.

Of the **287** inquests, there were two cases where the coroner was critical of the care provided and action has been taken to address these concerns. This has included providing evidence of ongoing work regarding Emergency Department escalation levels through the Building Better Care Plan including staff recruitment, mentoring and supervision.

Patient Experience

Patient experience is what the process of receiving care feels like for the patient, their family and carers. It is a key element of quality, alongside providing safe and clinically effective care. The Health Board has responsibilities for improving patient experience under the following key statutory responsibilities and policy frameworks;

- NHS Delivery Framework 2019/2020 (NHS Wales, April 2019);
- Listening and Learning from Feedback – A Framework for Assuring Service User Experience (Welsh Government, 2015);
- Healthcare Standards for Wales (Welsh Government, 2015)
- Wellbeing of Future Generations (Wales) Act 2014;
- Social Services and Wellbeing (Wales) Act 2014;
- Parliamentary Review of Health & Social Care in Wales (Welsh Assembly, 2018)

Patient Advice Liaison Support (PALS)

The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. PALS also helps to improve the NHS by listening to service users concerns and suggestions. Patient and service user experience journey starts at the beginning with first contact and ends with the last.

The PALS service are key to Patient Experience. The service was first piloted in the Centre region in July 2017 and following its success was rolled out to the East and West in April 2019. The PALS service is now fully operational, with teams based across the three regions of North Wales. This has vastly increased the capacity and effectiveness of the Patient Experience Service across BCUHB.

PALS Themes

First and lasting impression, receiving care in a safe supportive and healing environment and understanding of involvement in care. The following main sub themes were identified that involved service users about how to get more involved in their own healthcare through both positive and negative communication. Assisting patients to support coordination of care, infection prevention and control, nutrition, staff attitude, staffing levels issues and waiting times.

The PALS service continues to work collaboratively with a vast variety of agencies and work streams across all sectors, and has been seen to make exceptional, positive work in highlighting the service, promoting their work so that positive improvements can be made. This ensures that the voice of patients and people who access services are heard and made apparent in all arenas, such as;

- ICAN, supporting and working collaboratively with this service to promote and collect feedback to influence future developments
- Welsh Language Services, promoting the positive work this service provides in enhancing the use of the Welsh language in the hospital setting
- Dementia Services, collecting powerful patient stories and ensuring that areas are dementia friendly
- Paediatric and Community Services, networking positively so as to engage with patients to collect valuable feedback, ensuring paediatric services in the community can be improved
- Paediatric ward in Ysbyty Glan Clwyd Hospital supporting the use of the High 5, Low 5 to support the collection of feedback from children admitted to this ward. The High, low 5 is a method of collection of feedback from children admitted to the ward, by the use of two hands, one pointing upwards and one downwards. Children and parents are welcomed to write their positive and negative feedback on these hands.

Social Media

In line with a need to promote and publicise the work by carried out by the Patient Experience Team, the service have created a Twitter page account, promoting the positive work and developments to the service across BCUHB and to the public. Regular tweeting of events, enhancing our profile and the good work that is carried out across each service area, and ensuring that all information and any new developments are regularly tweeted by the team.

All the information regarding the Patient and Service User Experience team is presently being added on the intranet page, and presently being developed into categories that will be accessible for all those within BCUHB to read. It will have collective relevant information that is up to date, highlighting our strategy, our vision and our goals. It has information on patient stories, with a library of those collected by the PALS, Accessible Health Care, Learning material, and more recently, information regarding Covid 19, and the new Bereavement liaison support that we as a service provide.

Feedback

In line with the Assuring Service User Framework, the Patient Experience Service are striving to improve the quality of care by analysing, reporting and acting on the feedback and data received. The reporting of this feedback collected depends on the method for gathering data, which is from patient stories, care2shares consultations or the real time feedback surveys, and is provided quarterly on patient satisfaction with regard to PTR.

The feedback that is reported back demonstrates the overall performance of that service within the Health Board, as well as highlighting areas in need of improvement. This feedback can then escalated within the different departments. Additionally areas of good practice are also shared, and can be adopted across the whole of the Health Board. We can then encourage these areas to take ownership of identified variations in care, act upon them, and welcome feedback on the improvements that have been implemented.

The response rates in **Tables 15, 16, 17, and 18** demonstrates the data collected for the three acute hospitals across BCUHB, inclusive of the data for respective community hospitals. When compared to the previous quarter, this data illustrates that there is an improvement in performance across the board in relation to all of the questions where the response was given as 'Always'. The questions asked were; Did the staff introduce themselves? Do you feel that you were listened to? Did staff take the time to understand what matters to you? Did you get assistance when you needed it? Were you involved in decisions about your care? Were you given all of the information you needed?

Table 15

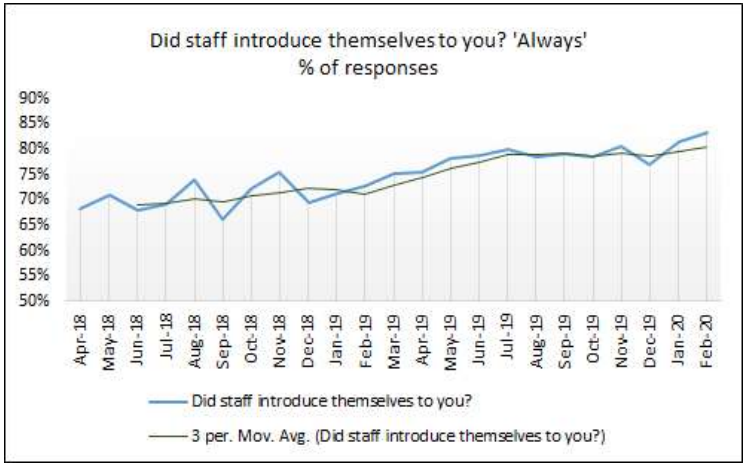


Table 16

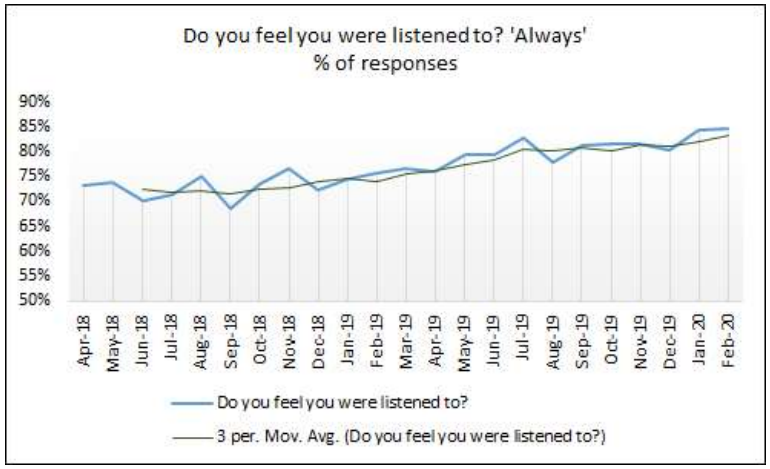


Table 17

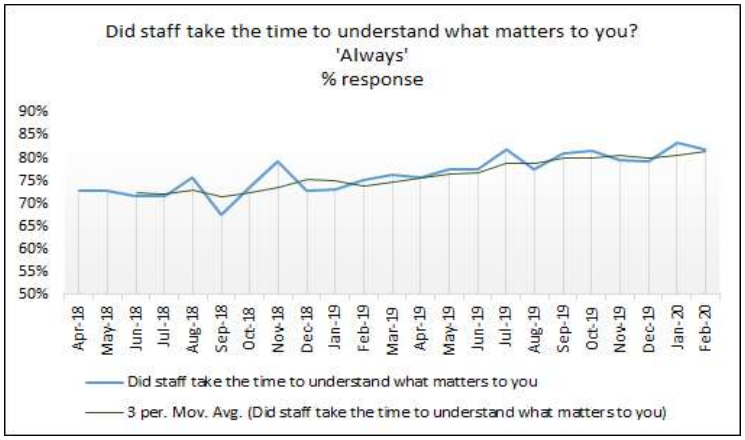
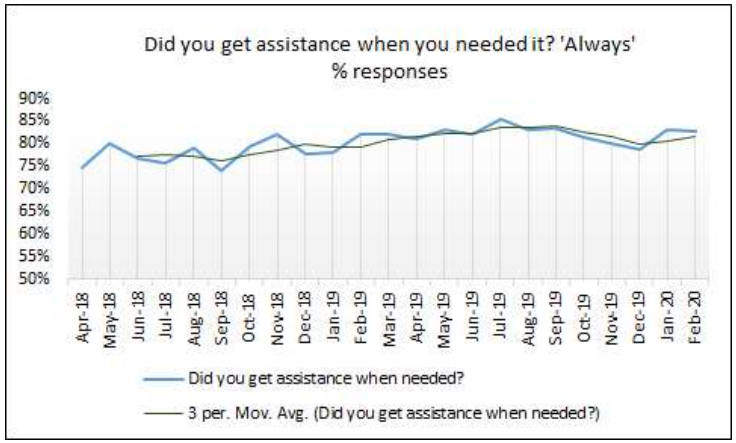


Table 18



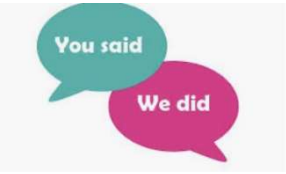
Welsh Language

The Health Board has continued to make progress in implementing its Welsh Language Scheme, with the focus now progressed to the implementation of the Welsh Language Standards under the Welsh Language Measure 2011. The Welsh Standards became applicable in May 2019.

A new Bilingual Services Monitoring Scheme was initiated in March 2018, to scrutinise the availability and quality of Welsh-medium services across the Health Board. 'Could you speak Welsh if you wanted to?' was introduced in May 2019 as a new question to the patient feedback survey to comply with the Welsh Language Standards. The figures are also gathered on a monthly basis by the Patient Experience service, and can be reported upon regularly so as to monitor the use of Welsh whilst patients stay in hospital.

There is a fluctuation across the West, Centre and East regions regarding satisfaction concerning whether or not service users were able to use the Welsh language if they so wished. Actions to improve compliance regarding the Welsh Language Measure includes an increased staff awareness of the requirement to offer the provision of services through the medium of Welsh. This ensures that the arranging of staff rotas takes into consideration the need to ensure we have sufficient Welsh speaking staff on different shifts, and evaluation of the language requirements for new staff posts.

You Said We Did



The Patient Experience Team reports on comments, query and questions raised, and report and feedback on what services have done to resolve these issues. We are therefore committed to provide more opportunities for service users to have their say so that positive changes can be made.

Based on reported patient experience feedback, all service areas identify emerging themes that encompass positive feedback in their services and also those areas that patients and service users felt needed improvement. The service areas were then asked to provide detail of the changes proposed so as to facilitate the improvement to happen. A few examples of positive and negative sub themes from different service areas across BCUHB are seen in **Table 19** reviewing key sources from real time feedback systems, patient comment cards, patient stories, care2shares, complaints and incidence trends, compliments and local surveys.

Table 19

You Said…….	We Did…….
Neurophysiology, North Wales Managed Clinical Services Directorate Positive: Compliments from service users to specific clinicians for their compassionate care in particular with vulnerable patients Negative: difficulties in locating department, lack of signage	**Action.** Compliments feedback to the services to highlight best practice of care in clinical areas. Video observations used with staff to further improve communication skills. **Action-** Revised bilingual maps and directions mailed out to all patients. Follow up reminders to the estate departments to complete outstanding work. Informed patients of current limited accommodation and plans on Maelor site including plans to refurbish these areas to reintroduce services
Wrexham Maelor Hospital, Secondary Care Positive: Staff attitude and across all areas. Compassionate, person centred care. Time for patient education regarding long term conditions Negative: Long waiting times in the Emergency Department, access to services planned in advance, staff attitude and level of noise at night	**Actions:** Recognition awards given at monthly staff leadership forums, also recognition given to the excellent work from different teams and departments within hospital care. Celebration of 'Feel Good Friday', where a positive comment is passed on to a nominated ward or member of staff every Friday. Positive comments and reports regularly recorded by the PALS. **Actions:** Emergency Department Medical and Nursing joint initiatives to improve waiting and access times. Roll out dementia friends who learn about dementia to support their community including training for staff. Reduction of the transfer of patients between wards. PALS provide a presence in Emergency Departments

Covid - 19 Pandemic

Patient Experience Bereavement and Liaison Support

As a consequence of the Covid-19 pandemic, the Patient and Service User Experience team have embraced new ways of working.

During the Covid-19 pandemic it is anticipated that the volume of families BCUHB Bereavement Officers will be supporting will increase, to support this service Patient Experience have developed a bereavement and liaison support service. The aim of the service is to listen, offer advice and support to patients, families, carers, and to liaise with staff and other organisations to facilitate additional support.

Links have been established within the Health Board in order to form an extensive support pathway for bereaved families. Referral forms have also been developed for the Chaplaincy and volunteer services. Partnerships are continuing to form with third sector agencies that will enable us to signpost effectively to the relevant agency to provide additional continued support for our service users. A 'Here to Help With Your Bereavement' booklet has been revised to include information surrounding Covid -19 pandemic and is now available to read online and is accessible in British Sign Language. In addition, following a successful funding application to Awyr Las, training and additional resources will be available to support the team. Promotional material, memory boxes, condolence and prayer cards along with reflective gardens are one of many developments in progress.

So far, we have engaged with a total of **28,906** individuals via social media. The service has also received 588 views on our webpage, 213 Facebook views, and 91 enquiries direct to the service.

Letters to Loved Ones

During the Covid-19 pandemic, visitors to hospitals have been restricted, which is why 'Letters to Loved Ones' has been established to maintain communication between loved ones and patients. This means that a message can be sent via email or passed over the telephone and that message will then be delivered to patient on the wards. A total of 315 requests have been received as at June 2020.

So far, we have engaged with **30,283** individuals via social media. The service has also received 2,814 views on our webpage, 1,740 Facebook views and 494 enquiries direct to the team. The Patient Experience team have received some heartfelt feedback from a loved one who has used our service;

"I would like to thank you for passing our emails on to our loved ones. You are all wonderful. It is so difficult for the patients not to have visitors, at this time and likewise, we cannot visit. Your service is a lifeline, which I for one is so happy about. Cards and letters are not reliable at this time. My brother is in Glan Clwyd. Many thanks. My clapping and whistle blowing on Thursday at 8pm will be especially for you. God bless. Best wishes to you all."

Make it Safe

In March 2020, the requirements for Welsh Government reporting changed in response to the onset of the Covid -19 pandemic. This meant that many incidents that would have been previously reported to Welsh Government were no longer a requirement; for example a fall resulting in harm.

In addition, the need to socially distance, work from home where possible and due to the increased workload pressures on clinical staff, serious incident reviews became more of a logistical challenge. In order to ensure the safety of patients and to identify learning at the earliest opportunity following a serious incident, a "Make it Safe" process was introduced into the Health Board. This process requires a review of the incident within 72 hours to ensure that anything that is required to make the situation safe is undertaken immediately and learning identified.

The completed "Make it Safe" documentation (for every serious incident) is submitted to the Associate Director of Quality Assurance and to the Head of Patient Safety for independent review. It is at this review that a decision is reached on whether the learning is appropriate and if further investigation is required.

Incidents are scrutinised and monitored at a monthly Quality and Safety Group, which is chaired by the Executive Director of Nursing.

Looking Forward: Aims and Priorities for 2020-2021

Our Aims and Priorities for 2020-21

A key focus of the Patient Safety and Experience Department in 2020/21 will be developing and implementing a learning framework and associated tools that support an emerging learning culture. Work is underway currently to develop initial basic tools including a new Patient Safety and Experience Newsletter and Online Learning Portal to support the sharing of learning across the Health Board. The Health Board PTR concerns procedure is currently under review into a single, simplified and easier to read document alongside the process reviews mentioned throughout this report.

The Patient Safety and Experience Department is planning a comprehensive review of the concerns process collectively, and this will be completed in co-production with divisions, patients and carers and other stakeholders, which include;

- North Wales Community Health Council
- Public Services Ombudsman for Wales
- H M Coroner
- Legal and Risk Services from the NHS Wales Shared Services Partnership

This work commenced in March 2020 and is coordinated by way of a Delivery Plan, which will help to ensure the delivery of the changes in a timely manner.

Running parallel to this will be the development and implementation of the new NHS Datix IQ Cloud system that enhances the delivery of efficient, targeted and effective care as well as the implementation of the anticipated Duty of Candor and a new national Serious Incident Framework, which is currently under review. The work underway in the Health Board will place a significant focus on human factors/ergonomics and system thinking approaches to investigations rather than a focus on root cause analysis, and the enhancement of a just culture based approach.

Our updated strategies, which include the Patient Safety, Patient Experience and Quality strategy, will strengthen the outcomes of our work and aid future improvement work and engagement.

Useful Information

Thank you for taking the time to read this report. If you have any queries, would like to request further information in relation to this report, or of you would like to keep up to date with news in relation to our services, please visit our website. Details of how to contact our Patient Safety and Patient Experience Team can be found at the 'Contact Us' page.

Our website https://bcuhb.nhs.wales/

Public Service Ombudsman for Wales

The Public Services Ombudsman for Wales has legal powers to look into complaints about public services and independent care providers in Wales. The Ombudsman also investigates complaints that members of local government bodies have breached their authority's code of conduct. He is independent of all government bodies and provides a free and independent service.

https://www.ombudsman.wales/

North Wales Community Health Council

The North Wales Community Health Council (NWCHC) is the independent health watchdog for North Wales. It represents the interests of patients and the public who use our health services. There are times we all need help to speak up about concerns/complaints if patients, carers, relatives feel let down by the Health Board or Social Care service. The NWCHC Advocacy Service can help raise those concerns/complaints through its role in providing a free, independent, confidential, non-legal, client-led service. NWCHC are able to help patients or their representative in making a complaint under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

http://www.wales.nhs.uk/sitesplus/900/home