ANNUAL REPORT: PUTTING THINGS RIGHT

2018/19

Concerns, Incidents, Compliments, Claims & Redress cases for 2018/19

TABLE OF CONTENTS

Table of Contents

TABLE OF CONTENTS

EXECUTIVE SUMMARY

INTRODUCTION

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (the Regulations) came into force on the 1st April 2011, to enable Responsible Bodies to effectively handle concerns.

The aim of the regulation was 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)

PURPOSE

This annual report has been prepared in line with the Regulations and is intended to provide an overview of the 2018/2019 position in terms of how the Health Board has managed Concerns for the period. It provides an overview of themes and trends emerging from Concerns and a high-level summary of lessons learnt. It is not intended to provide detail on learning in individual cases; this is shared on a regular basis through the Divisional Quality and Safety Groups, the BCUHB Quality and Safety Group and the Quality, Safety & Experience Committee.

BACKGROUND

Sometimes things do go wrong and we let our patients down but concerns remain a rich source of intelligence to support our Goals. We respond to the concerns (complaints, claims and serious incidents) raised in line with PTR, to investigate and ensuring that the concern is dealt appropriately, identifying areas for learning and to improve the quality of care.

EXECUTIVE SUMMARY

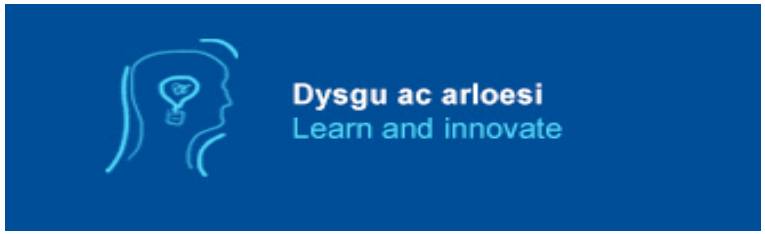
BACKGROUND

As a Health Board, our Corporate Goals include:

- Improve the safety and outcomes of care to match the NHS's best
- Respect individuals and maintain dignity and care
- Listen to and learn from the experiences of individuals
- Support, train and develop our staff to excel

CONCERNS CONTEXT AND ACTIVITY

Efforts are made to resolve concerns raised by patients/service users and their carers/relatives as they arise; these are referred to as 'on the spot'. In 2018-19, the Health Board recorded 3,455 concerns, which were resolved 'on the spot'. However, some patients/service users, their carers/relatives choose to make a formal complaint. These totalled 1,408 in 2018/19, a decrease of 18 (>1%) on the previous year.



CONCERNS MANAGEMENT

All Concerns are managed in line with the PTR regulations and Being Open principles and policy. Efforts are made to contact a complainant and clarify the issues being raised to ensure we answer their concerns correctly the first time. Where possible, and for cases where there is no allegation of harm, the Health Board will offer the complainant early resolution and resolve these as an 'On the spot'. Complaints managed on his basis must be resolved to the complainant's satisfaction. Should this not be possible it will be managed as a formal complaint in line with PTR.

There has been significant improvement in the number of complaints open overall, and the timeliness of responses. This remains challenging but actions are ongoing to continue to improve.

In terms of incidents, the introduction of the rapid review for all serious incidents is aimed at improving the level, robustness and timeliness of investigations.

EXECUTIVE SUMMARY

COMPLAINTS

During 2018/19 there was a concerted focus on improving the timeliness of resolving complaints. At the end of March 2019 there were 183 (54%) cases open over 30 days out of a total of 342 active cases.

The 30 day target improved through 2018/19; this was however variable ranging from 25% to 40% with an average of 34%. This position was positive in light of the ongoing work to reduce the overall number.

NATIONAL INDICATORS OF CONCERNS MANAGEMENT

In 2018/19, there were 1,408 formal complaints received (and 1,300 closed). The overall performance compliance rates were as follows:

- Complaints acknowledged within 2 working days - 93%
- Complaints responded to within 30 working days – 34% average

COMPLIMENTS

A total of 810 expression of thanks/positive feedback comment cards were received and recorded on the Datix system with many more thank you cards received directly by wards and departments.

PATIENT ADVICE AND SUPPORT SERVICE

The PASS is available at Glan Clwyd Hospital, serving secondary and community services in the central area. The *PASS* officers will listen to any comments or suggestions service users and the public have, and make every effort to resolve any issues as soon as possible. They also provide details of other organisations that can provide information or advice. It is intended to rebrand this service and extend it to the other areas of the Health Board overtime.

EXECUTIVE SUMMARY

SERIOUS INCIDENTS

A total of 32,458 incidents were recorded onto the Datix System, of these 24,384 (75%) were patient safety incidents of which 867 (2.6%) were recorded as serious incidents and reported to Welsh Government.

These numbers are lower than the previous year.

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, either:

- clinical/medical negligence claims
- personal injury claims

.

CLAIMS

During 2018/19, the Health Board received 282 new claims and had a total of 800 claims open. Payments totalled £22,346,261 in damages and claimants costs and £1,051,205 in defence costs with the Health Board contributing £2,965,180 (£25,000 per case) in line with Welsh Government Risk Pool requirements.

These numbers are higher than the previous year.

EXECUTIVE SUMMARY

SUMMARY

The main challenge for the Health Board throughout the financial year has been to manage its concerns in a timely way. The Health Board recognises that staffing issues and significant operational pressures have contributed to some investigations being delayed, and offers its unreserved apologies to those who have been affected.

Significant work has been undertaken to combat this, to include investment to develop the Patient Advice and Support Service (PASS), initially in Ysbyty Glan Clwyd. This will be rolling this out to the other areas during 2019/20. This service provides support, advice and resolution to patients, and awareness of the Service is raised amongst staff, and members of the public, across all hospital sites. The serviced will be rebranded as Patient Advise and Liaison service (PALs) as from April 2019.

During the past financial year the central concerns team received 1,880 concerns, of which 980 were resolved by PASS (with early intervention to the complainant's satisfaction) and 900 concerns required an investigation under PTR.

For detailed information about "Putting Things Right: Raising your concerns about the NHS", please follow the website link : http://howis.wales.nhs.uk/sites3/Documents/932/Healthcare%20Quality%20-%20Guidance%20-%20Dealing%20with%20concerns%20about%20the%20NHS%20-%20Version%203%20-%20CLEAN%20VERSION%20%20-%2020140122.pdf

SUMMARY

Much work has been undertaken in 2018/19 including concluding a significant number of overdue complaints. There has been a review of the Concerns PTR procedure and the introduction of a rapid review for all serious incidents. This has improved the immediate learning and sets in motion the investigation process in a timelier manner.

EXECUTIVE SUMMARY

SUMMARY

The divisions are focused on putting in place sustainable structures and procedures that assist learning and improvement

Each division has also further developed their governance structures to ensure Concerns are managed as part of the quality and safety structures.

An increased emphasis on contacting complainants directly on receipt of a complaint has been pursued during the year in an effort to resolve complainants earlier, and to ensure the investigation is focused and answers the right questions from the complainant's perspective.

The Health Board is highly committed to improving the patient experience, welcoming feedback from patients and continually improving systems and processes which seek to improve clinical outcomes and experiences for our patients.

For people who work in healthcare, as well as service users, it really does make a difference to know that what is being done has helped to make someone's experience better.

Positive feedback has been received during the year via 'Viewpoint' our real time feedback system, Comment cards and monthly patient questionnaires. Providing easier ways for patients (inpatient and outpatients), their families and members of the public to feedback their experiences, whether good or bad, and improving services based on this information is a priority for the Board.

During 2018 two external reports were received by the Health Board, the HASCAS investigation report and Ockenden Governance Review. These reports include comments and recommendations related to complaints handling. The themes included:

- Respond in a timely manner
- Be clear regarding how to make a complaint
- Be clear what happens once a complaint has been made
- Listen to the complainant
- What support is there for a complainant

COMPLAINTS

Overview arrangements for managing concerns

The Chief Executive has overall responsibility for dealing with concerns. This responsibility has been delegated on a day-to-day basis as described below:

- *The Executive Director of Nursing* has delegated authority on behalf of the Chief Executive to ensure that there is a robust process in place to support the effective management of the concerns process. This transferred from the Director of Corporate Services in May 2017.
- *The Divisional Nurse Directors* for secondary care, Areas and Mental Health services are responsible for the delivery of investigations into Concerns and for ensuring lessons are learnt.
- *A Concerns Champion*, an Independent Board Member, has a strategic and scrutiny role to monitor the Board's handling of concerns.

Overview of the Concerns Process

- In line with the Regulations, the Health Board receives Concerns (complaints) into a single point of contact. All complaints are received by the Corporate Concerns Hub and reviewed by the relevant Corporate Concerns Team, graded according to the PTR guidance (level 1-5) based on levels of potential harm and relevant consent obtained. All Concerns are entered onto the Datix integrated management system and passed to the relevant Division or corporate function for investigation and to draft a response.
- Incidents are entered directly onto the web based Datix integrated management system by staff.
  These are reviewed by senior staff and investigated appropriately. Learning and outcomes should be recorded on Datix and when the senior management team are satisfied the incident is closed on Datix and staff reporting the incident should receive feedback.
- The Regulations promote open and transparent investigations, "Investigate once investigate well". The level and depth of the investigation is proportionate to the grading and complexity of the concern.

COMPLAINTS

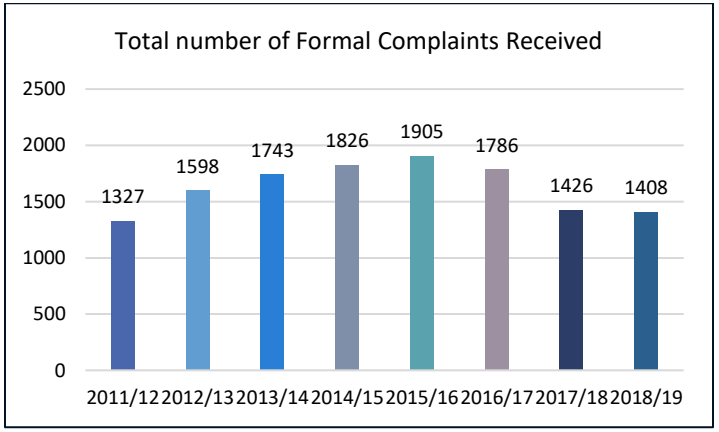
Overview of improvements during 2018/19

- Decrease in total number of complaints and serious incidents open and overdue
- Restructuring of corporate and divisional teams to better manage complains and incidents
- Strengthening of the initial stages of the investigation to identify early learning and actions to make safe
- Review of processes and procedures
- Provision of training programmes related to concerns management
- Introduction of an online complaints form
- Review of response letters for complaints under Putting Things Right
- Audits of all main sites to ensure posters and leaflets available on how to complain
- Develop an updated video clip in BSL to inform people who use BSL of how to make a complaint. This is being developed as part of the All Wales network

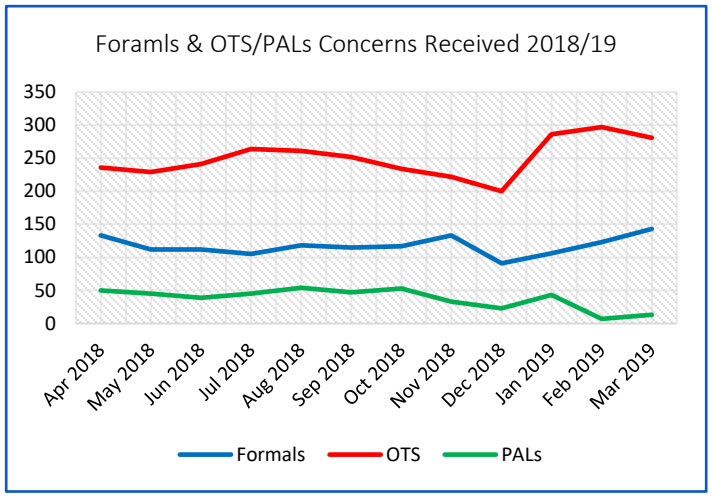
Complaints activity:

In 2018-19, the Health Board recorded 3,455 concerns which were resolved “on the spot” (split between the Concerns and PALs team) this is a decrease from 2017-18 of 692. Every effort is made to resolve concerns raised by patients/service users and their carers/relatives as they arise and figures this year are encouraging that the Health Board has been more effective in this area.

However, some patients/service users, their carers/relatives choose to make a formal complaint. These totalled 1,408 in 2018/19, a decrease of the previous year of just over 1%.



COMPLAINTS



Complaints received are categorised by each Division – Area (x 3), Secondary Care including Women's and Childrens services, and Mental Health and Learning Disabilities (MHLD).

The Health Board launched an online form to make sharing concerns with us easier. This can be found at - https://www.smartsurvey.co.uk/s/BCUHBconcernsform/

There is a requirement to acknowledge the receipt of a formal complaint within 2 working days.

Complaints Acknowledged in 2 Working Days

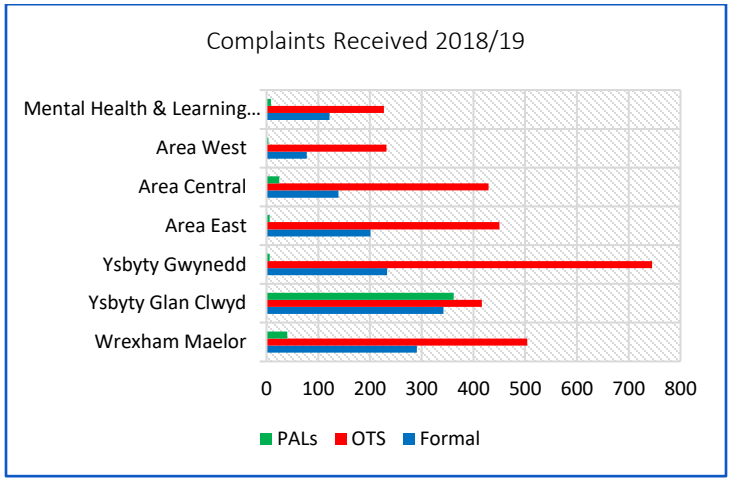
93%

Of the total formal complaints received (1,408), 1,312 were acknowledged within 2 working days against a target of 100%.

The 100% target was not achieved in 2018/19 due to a number of factors including staffing issues including sickness/vacancies in the Corporate Team and delays in complaints received outside of the Corporate Hub being forwarded to the Corporate Concerns Teams for acknowledgement.

Actions have been taken to ensure all staff are aware of the need to forward complaints received outside of the Hub to the team as soon as possible. However, complainants do continue to write to other addresses, despite extensive information available on how to complain.

COMPLAINTS



Complaints Response times

34% (ave)

The Regulations require complaints to aim to be responded to within 30 days of receipt. Of the total 1,408 formal complaints received of which 1,086* (86%) have been closed. Of these, 430* (34%) were responded to within 30 working days.

**Excluding March 2019, as concerns received still within time for investigation*

93%

For more complex cases the Regulations allow an extended time for response of up to 6 months, but require the complainant to be kept informed of progress throughout the process. During 2018/19, 93%* of cases were closed within 6 months.

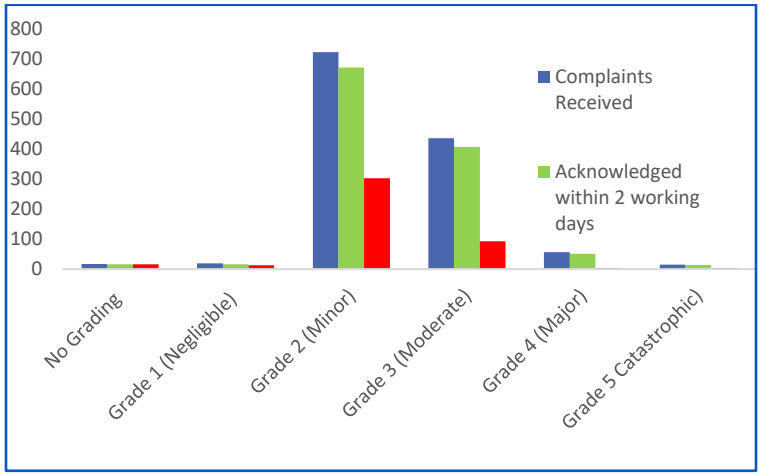
Significant effort was put into closing all historic complaints that remained open and this was is monitored as part of the Special Measure Framework.

Complaints by Initial Grading

All formal complaints received are graded on receipt in line with the All Wales grading framework and this informs the level of investigation required for the complaint. The grading represents the assessed level of harm on an ascending basis with grade 1 being no harm.

COMPLAINTS

In 2018/19* the majority of complaints received were graded at grade 2.



**Excluding March 2019, as concerns received still within time for investigation*

Of the formal complaints received in 2018/19, the top 3 reasons for making a complaint were:

On The Spot Concerns – Most received by subject	**Total**
Access, Appointment, Admission, Transfer, Discharge	1139
Consent, Confidentiality or Communication	884
Abusive, violent, disruptive or self-harming behaviour	274

Formal Concerns - Most received by subject	**Total**
Treatment, procedure	395
Consent, Confidentiality or Communication	314
Access, Appointment, Admission, Transfer, Discharge	269

Every complaint offers the Health Board an opportunity to learn and improve the services we offer to our service users.

Examples of things changed as a result of a complaint are:

COMPLAINTS

Examples of learning from complaints:

You Said	We Did
Concerns regarding patients on an End of Life (EoL) Pathway who have not been triaged appropriately (i.e. prioritised) when contacting GP Out of Hours (GPOOH) Service	As a result of patient and family experience, GPOOH have implemented systems to be more alert to patients on an EoL pathway. Systems are now in place to put an alert on the IT system, allowing for review of patients known to be on EoL pathway. This enables the service to prioritise better by blocking off appointments (for a GP to attend a patient at home if required). Similarly, District Nurses may be asked to attend if patients and family require input and support to ensure that all efforts are made to keep patients in their own home and in accordance with their wishes.
You said that waiting times in our Emergency Department were too long	We have introduced a Single Integrated Clinical Assessment & Triage Service that has ensured that only patients who absolutely need to be in the Emergency Department are conveyed to hospital. So far, about 750 unnecessary admissions to hospital have been avoided.
Patients have complained that we have not been taking enough notice of patient's likes and dislikes particularly if the patient has a diagnosis of dementia.	The Health Board has relaunched the 'This is me' document that is used to provide details about a person living with dementia and ensures the ward staff understand more of a patient's personal history and background including details of a person's cultural and family background.

P.A.S.S.

Number of Comments

17875

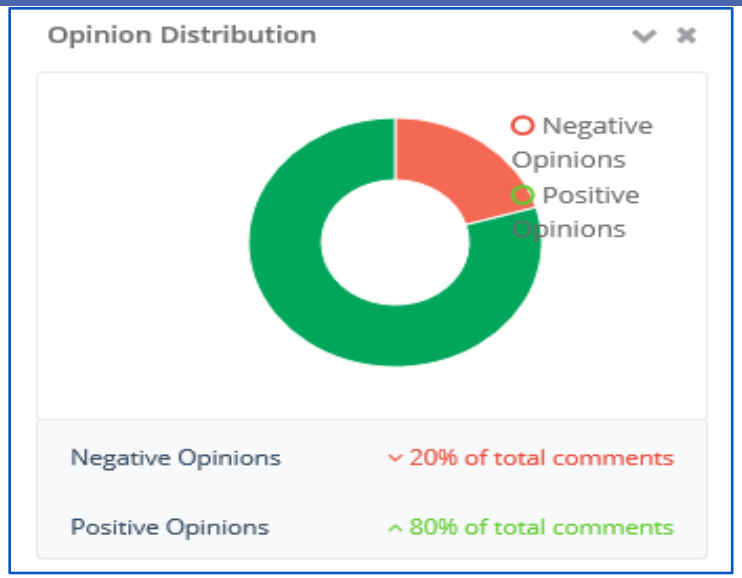
comments

Positive Opinions

48715

Negative Opinions

12530



A regular report on themes and trends from the PASS service is provided to the Hospital Management Team to support and inform the improvements to services on an ongoing basis.

P.A.S.S.

Theme	No Comments	Opinions	
Communication	2403	-ve 1123 opinions	+ve 3491 opinions
Pain	129	-ve 188 opinions	+ve 180 opinions
Treatment	2418	-ve 937 opinions	+ve 5052 opinions
Medication	125	-ve 95 opinions	+ve 109 opinions
Discharge	405	-ve 261 opinions	+ve 497 opinions
Disturbance	99	-ve 95 opinions	+ve 116 opinions
Nutrition and Hydration	808	-ve 382 opinions	+ve 1049 opinions
Respect & dignity	715	-ve 352 opinions	+ve 1230 opinions
Staff Behaviour	8108	-ve 2785 opinions	+ve 13857 opinions
Environment	1160	-ve 707 opinions	+ve 1649 opinions
Efficiency	6165	-ve 2333 opinions	+ve 9870 opinions
Improvement	1606	-ve 1008 opinions	+ve 2637 opinions

HASCAS & OCKENDEN REPORTS

Independent Investigation Completed by HASCAS Consultancy Limited

In September 2015, the Health Board commissioned HASCAS Consultancy Limited to lead an independent investigation in relation to the complaints, concerns and professional regulation and employment issues arising from the significant failings in care on Tawel Fan ward.

HASCAS Consultancy Limited published the Lessons for Learning Report on 3rd 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 of families and staff and reviewing of over half a million pages of information including police transcripts, medical records, staff records and corporate records.

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

What the Health Board did next

Putting Things Right (PTR)

Following release of the Lessons for Learning Report, the Health Board commenced the work of sharing the individual patient reports with Tawel Fan patients and families. Each of the individual patient reports were received between May and August 2018 and the Health Board worked through the individual patient reports to produce an accompanying PTR response letter.

All active cases for the 105 individual patient reports were successfully delivered to Tawel Fan patients and families between June and September 2018.

In terms of Redress, of the total 105 reports received, 60% were Regulation 24 (determined no harm caused) and 40% were Regulation 26 (determined harm caused).

Between June and October 2018, 19 meetings have been held with patients and/or relatives to review their individual report and Putting Things Right (PTR) letter.

HASCAS & OCKENDEN REPORTS

In terms of the Ockenden report, the recommendations were accepted by the Health Board, as were the recommendations of the HASCAS report and work streams to address the improvement required were put in place.

Commencement of the Improvement Group and Stakeholder Group

Gill Harris Executive Director of Nursing & Midwifery, established a taskforce comprising an Improvement Group and a Stakeholder Group in August 2018. The Improvement Group meets bi-monthly and monitors the actions identified for each recommendation, led by an operational lead.

The Stakeholder Group, which is a subgroup of the Improvement Group, has membership from representatives of the Community Health Council, Bangor University, St Kentigern Hospice, North Wales Police, North Wales Local Authorities, Community Voluntary Councils, North wales Adult Safeguarding Board and Care Forum Wales, as well as Tawel Fan family members. The aim of the group is to provide external scrutiny and input to guide the work of the improvement group.

HASCAS and Ockenden recommendations- one year on

The work of the Improvement Group and Stakeholder Group has since evolved due to the significant work undertaken to drive forward the recommendations.

The Stakeholder Group meets on a quarterly basis and Stakeholder members have started to engage directly with operational leads and respective working groups established for some of the recommendations and contribution is being made to some of the work.

Progress has been made with each of the 36 HASCAS and Ockenden recommendations, with 20 recommendations on track to deliver and some due to complete, 13 are in progress and require some additional focus or support to address some challenges and 2 are completed; these are relation to Board Development and the recruitment of the second Consultant Nurse for Dementia (due to commence in the role on 17th June 2019)

OMBUDSMAN

Public Service Ombudsman for Wales (PSOW)

Complainants, if not satisfied by the Health Board response to their complaint, can ask the Public Service Ombudsman Wales to undertake a further independent investigation.

In 2018/19, 137 complainants made the decision to approach the Ombudsman. Of those 137 cases, the Ombudsman decided to investigate 49 cases, 37 enquiries were received where the Health Board were requested to provide PSOW with information , 22 cases were not investigated by the Ombudsman and 29 were dealt with as a Proposal where the Heath Board agreed to carry out actions in order to resolve outstanding issues. These figures are slightly lower than 2017/18, when 146 people approached the Ombudsman who decided to investigate 70 cases; during 2016/17, 134 people reported their case to the Ombudsman with 59 cases being investigated.

Of the 49 cases investigated during 2018/19, 9 have been either fully or partially upheld and 7 were not upheld. Information on the remaining 33 cases has not yet been received from the Ombudsman's Office 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/

Public Interest S16 Cases

The PSOW does not routinely publish his reports, however where there is significant concern regarding the matters investigated, the PSOW will issue a Public Interest Section 16 report.

BCUHB have not received any Section 16 reports during 2018/19 compared to 2017/18 when the Ombudsman found serious failings in two cases from BCUHB, which were reported as Section 16 public interest reports.

Ombudsman Ombwdsmon
PUBLIC SERVICES OMBUDSMAN FOR WALES
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU

REDRESS

Redress

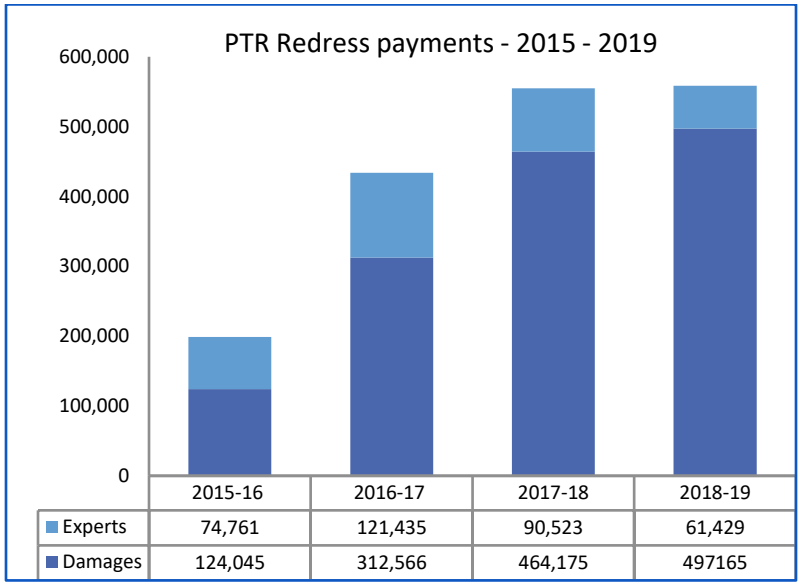
Whilst the Health Board always strives to ensure it delivers the best possible care and treatment, sometimes things may not go as well as expected. When that happens, there are Regulations which the Health Board must follow to consider whether what has gone wrong has caused the patient any harm. If it 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).

The Health Board concluded 94 cases under the Putting Things Right (PTR) Redress Regulations in 2018/19 compared to 81 during 2017/18:

- Financial compensation as redress - 75
- Apology only as redress -1
- Concerns which exceeded the amount of financial redress allowed under the PTR limit - 18

Putting Things Redress Costs



Learning from Redress cases:

For each case where something has gone wrong and it has caused harm, evidence of action taken in an endeavor to reduce the risk of recurrence had to be provided to the Welsh Government (Welsh Risk Pool with effect from July 2018).

Examples of learning from the redress cases concluded within 2018/19 include:

REDRESS

What went wrong	Impact on Patient	Action Taken
Six month delay in patient obtaining correct cushion for motorised wheelchair	Deterioration in spinal posture as a result of being bed bound whilst for cushion	System introduced to ensure mobility equipment is quality checked by specific staff
Patient fitted with IUS (coil) without pregnancy being ruled out	Patient suffered a miscarriage	Changes implemented in how clinics are managed and patients assessed
Delay in diagnosing prostate cancer	Patient caused additional symptoms unnecessarily	Multidisciplinary review of Urology services produced plan for future provision of services
Patient did not receive procedure she had consented for and was discharged without being told.	Patient continued to experienced symptoms and required further surgery	Clinical Director sent a communication to all medical staff to ensure all patients are given a full de-brief after surgery
Failure to explain the potential side effects and complications before administering medication to patient.	Extravasation caused discolouration of patient's arm	New information provided by the University of Wales in reducing risk of staining following extravasation of an iron infusions, shared with staff
Patient discharged without medical review following episodes of hypoglycemia and elevated NEWS	Patient would not have died when she did had she remained in hospital	The BCUHB algorithm for the hospital management of hypoglycaemia in adults with diabetes has been reviewed and amended A ward development plan has been written in conjunction with senior hospital nursing staff to improve care and documentation in relation to patient dietary requirements, discharge, and monitoring of patients with diabetes and acute illness.

INCIDENTS

During 2018/19 a total of 32,458 incidents have been reported, of which 24,384 were patient safety incidents.

When Incidents are reported they are scored using a severity matrix. The table below sets out the recording of all patient safety incidents reported.

Severity	*2017/18*	*2018/19*	*Increase/Decrease (%)*
Negligible	18,358	18,073	(-) 1.5%
Minor	3,770	3,888	(+) 3%
Moderate	2,201	2,203	(+) .09%
Major	276	140	(-) 49%
Catastrophic	112	78	(-) 30%

*These terms are standard terms used as part of the grading system within the electronic recording system.

Numbers of serious incidents have decreased significantly over the past year.

Of the 78 cases graded as catastrophic, the table below shows the reported reason for these. Each incident is investigated to the appropriate level guided by the grading.

In 2018/19 a weekly incident review meeting has been established. This is chaired by the Associate Director of Quality and Assurance and attended by all divisions across BCUHB. The meeting reviews all serious incidents reported on Datix in the previous 7 days. These are broadly categorised as those graded as catastrophic, major, Never Events however any incident deemed by the division to need discussion can be presented. Upcoming inquests will also be reviewed and all serious or significantly overdue complaints.

INCIDENTS

Incident description	Lessons learned	Actions
Delay in diagnosis of fracture following an initial assessment in the Emergency Department (ED)	• Importance of assessing both hip and knee when patients complain of pain due to the possibility of referred pain. • A full joint examination (hip/knee) should be carried out and clearly documented in the case notes, even if there is no suspicion of fracture, or if the x-ray shows 'normal' appearances. • Admission discharge transfer (ADT) team involvement is recommended for all elderly patients with a history of fall (this service is available in ED)	Development of flow-chart within ED to be followed by clinicians when assessing patients presenting in ED after a fall. The learning was shared via Departmental Governance meetings as well as being communicated widely amongst ED clinical staff.
Delay in identifying the need for emergency Caesarean section in a patient admitted with decreased fetal movement (DFM) and an abnormal fetal heart monitoring (Cardiotocography CTG).	• Identification and consideration of risk factors, such as reduced fetal movements, must be standard practice when reviewing CTG. It is also important to ensure an holistic approach, including face to face review taking into account risk factors for both mother and baby when making management decisions.	Learning was shared via directorate governance meetings. A review of the Caesarean Section Integrated Care Pathway is currently being undertaken by the Improvement Midwife and BCUHB Pathways Lead.

INCIDENTS

Incident description	Lessons learned	Actions
Inpatient falls, some resulting in harm are all are investigated in line with BCUHB policies.	Common learning from falls includes: • failure to complete the Falls Pathway fully – and no mechanism in place to alert staff that elements of the pathway remained incomplete • Failure to complete next of kin information in the Falls Risk document – important in the presence of a dementia diagnosis as in this case. • Failure to utilise a 'Post Falls' sticker in the patient notes. The sticker was being trailed in this area at the time of the fall.	All ward staff have been reminded of the importance of completion of all BCUHB documentation to the required standard. This has been achieved via the ward team meeting, by the Lead Nurse, Deputy Lead Nurse and Ward Manager. Staff were also reminded that the 'Post Falls check sticker' must be used for every patient following a falls incident. Compliance is monitored by way of: • Spot checks • Weekly quality and safety walk rounds (Deputy Lead Nurse) • Monthly documentation audits • Monthly quality and safety audit. Learning from previous falls has identified the importance of using patient Falls Tab Alarms; ensuring appropriate, non-slip footwear is worn; increasing staffing levels in line with increased care needs of patients on the ward; use of high/low beds to minimise the risk of harm should a patient fall from bed.

INCIDENTS

All serious incidents recorded on Datix go through a final validation process prior to uploading to the National Reporting and Learning System (NRLS). This is carried out on completion of the investigation. A significant number of incidents are downgraded from catastrophic if the investigation concludes that BCUHB did not cause harm. The validation work for 2018/19 had been partially completed at the time of preparing this report (64 of the 78 not validated as still under investigation), thus the numbers of confirmed catastrophic incidents is very likely to be lower than reported above.

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.

867 incidents were reported (excluding no surprises/sensitive issues) to Welsh Government in 2018/19. This is a decrease of 72 on 2017/18. By the end of March 2019 there were 291 still open for 2018-19, 223 of which were overdue. This represents a closure rate within 60 working days of 22%.

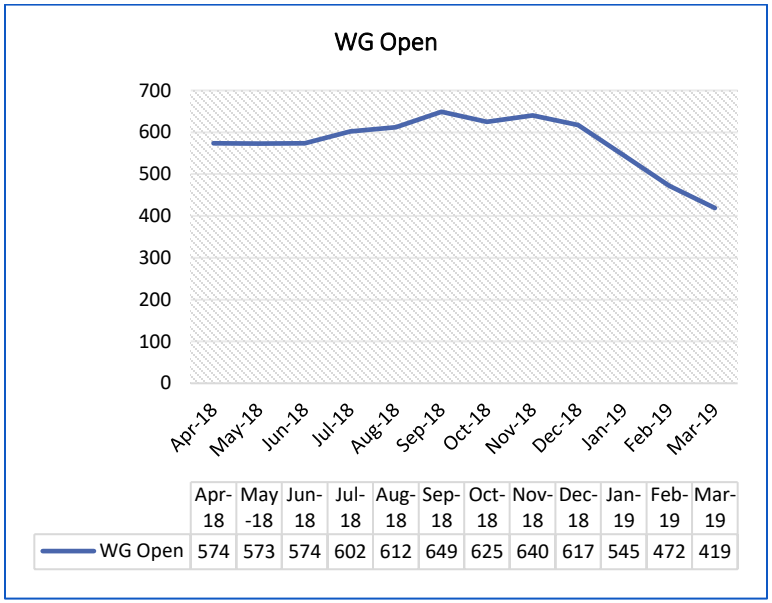
Of those reported in 2018/19 the top 3 reasons for reporting were:

Grade 3 or above hospital acquired pressure ulcer develops - 484 *(down 5% on previous)*

Unexpected death whilst under the direct care of a health professional - 139 *(up 2% on previous)*

Patient falls resulting in harm/death to patient – 116 *(up 2% on previous)*

The outstanding historic cases remain open mainly due to other statutory investigations such as Protection of Vulnerable Adults (POVA) investigations preventing internal investigation being concluded. Further work has been progressed to ensure that all historic cases in the gift of the Health Board are closed.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
WG Open	574	573	574	602	612	649	625	640	617	545	472	419

NEVER EVENTS

Some serious incidents are categorised by the Department of Health and Welsh Government as "Never Events" (things that are largely preventable and should never happen).

In 2018/19 there were 8 'Never Events' recorded:

- Misplaced Naso or oro-gastic tubes
- Overdose of Methotrexate for non-cancer treatment
- 2 incidents recorded as retained foreign object post-operation
- Wrong route administration of medication
- 3 incidents recorded as wrong site surgery

All of these cases were fully investigated and closed with identified learning.

Case 1 – 14.05.18

Never event classification: Wrong site surgery

Incident: biopsy from wrong side

The learning included:

- World Health Organisation (WHO) Safer Procedure checklist modified for all procedures undertaken in the department;
- When site not clear / secondary issues in same area – photographs are taken with patient's consent and marked to indicate site that biopsy is to be taken from.

Case 2 – 21.06.16

Never event classification: Overdose of Methotrexate for non-cancer treatment

Incident: Poor transcription of a drug chart

The learning included:

- Consultant ward rounds include review of the drug charts **on every occasion** (drug charts will not go to pharmacy at these times);
- additional pharmacy staff capacity has been committed to long-term to improve clinical checking of charts;
- Relevant staff have been retrained on the transcribing policy;
- Methotrexate prescribing and administration has been added into the back to basics training for registered nurses.

Case 3 – 10.08.18

Never event classification: Retained foreign object post-operation

Incident: cotton wool ball retain following a clinical procedure

The learning included:

- Gauze balls (radio opaque) as opposed to cotton wool balls now in use across the 3 sites;
- Pre packed packet of 5 balls now used to aid counting;
- Ball count completed prior to and after procedure and recorded.

Case 4 – 21.08.18

Never event classification: Misplaced naso or oro-gastric tubes

Incident: misplacing of an intubation tube

The learning included:

- routine use of capnography (the monitoring of the concentration or partial pressure of carbon dioxide (CO_2) in the respiratory gases) implemented for all intubated patients;
- The anesthetic induction programme for Doctors reviewed to ensure awareness of all high-risk areas are included.

Case 5 – 19.09.18

Never event classification: Wrong route administration of medication

Incident: a local anesthetic nerve block administered to the wrong site

The learning included:

- Clinical Alert 'Stop before you Block' redistributed to all Clinical staff;
- The induction process for new doctors now includes mentorship and close monitoring procedures;
- 'Stop before you block' checks added to WHO Surgical Safety Checklist

NEVER EVENTS

Case 6 – 25.09.18

Never event classification: Wrong site surgery

Incident: a local anesthetic nerve block administered to the wrong site

The learning included:

As for case 5 – two incidents investigated jointly

Case 7 – 25.09.18

Never event classification: Wrong site surgery

Incident: cardiac catheter inserted in wrong blood vessel

The learning included:

- Relevant Standing Operating Procedures written to ensure universal approach to care in line with national guidance
- training of clinical staff as appropriate

Case 8 – 07.12.18

Never event classification: retained foreign object post operation

Incident: guidewire for a central line not removed as required

The learning included:

The incident was confirmed as human error and in fact the clinical involved identified to error themselves.

- Clinical alert issued to remind other clinicians
- Individual undertook reflection and learning
- Signed ‘sticker’ added to case notes confirming removal of guidewire

HER MAJESTY'S CORONER

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. In 5 cases the coroner was critical of the care provided and action has been taken to address these concerns.

The relationship with the North Wales Coroners and their officers has continued to develop, with the Heads of Concerns (previously known as the Senior Investigation Managers) being the main Health Board point of contact. The Coroners have previously expressed concern regarding the timeliness of the submission of Incident reports and also regarding assurances that appropriate actions had been taken. By improved utilisation of the DATIX system there is now a cross reference between Coroners' Inquests and incidents and complaints investigation.

289 inquests were held in relation to patients under the care of the Health Board during 2018/19.

Coroner's Rule 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 were known as "Reports on actions to prevent future deaths – Rule 28"

The Health Board has been issued with 5 rule 28 reports during 2018/19, 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.

Case 1 – 17.05.2018

The report expressed concerns in regards to a number of factors including (but not exclusively) capacity and patient flow problems, staffing issues and administrative/escalation failures, there was a delay in the patient being assessed and treated, and the patient's condition deteriorated, and sadly the patient passed away in the early hours of the following morning.

Learning in this case related to the following

- The Health Board has revised the model for investigating serious incidents
- The Health Board has introduced a weekly Incident Review Meeting; the meeting is chaired by the Associate Director of Quality Assurance and attended by senior staff
- Project Management approach to be used when conducting a comprehensive investigation with milestones for completion

Case 2 – 12.06.2018

The report raises issue of ambulance delays, admission to the Emergency Department/availability of resources/patient flow and the multi factorial problems associated with cases of this nature

Learning in this case related to the following

- Work to improve assessment times / flow in ED

Case 3 – 26.06.2018

The report raises issue of ambulance delays, admission to the Emergency Department/availability of resources/patient flow and the multi factorial problems associated with cases of this nature

Learning in this case related to the following

- Work to improve assessment times / flow in ED

Case 4 – 12.09.2018

The report raises issue of ambulance delays, admission to the Emergency Department/availability of resources/patient flow and the multi factorial problems associated with cases of this nature

Learning in this case related to the following

- Work to improve assessment times / flow in ED

Case 5 – 11.02.2019

The report raises issue of ambulance delays, admission to the Emergency Department/availability of resources/patient flow and the multi factorial problems associated with cases of this nature

Learning in this case related to the following

- Work to improve assessment times / flow in ED

CLAIMS

Claims Management

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, either:

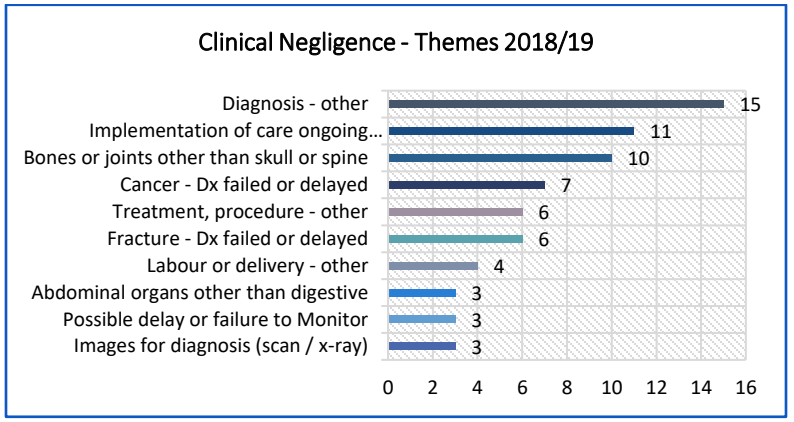
- clinical/medical negligence claims
- personal injury claims

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 will reimburse the Health Board for all losses incurred above an excess level of £25,000 on a case by case basis.

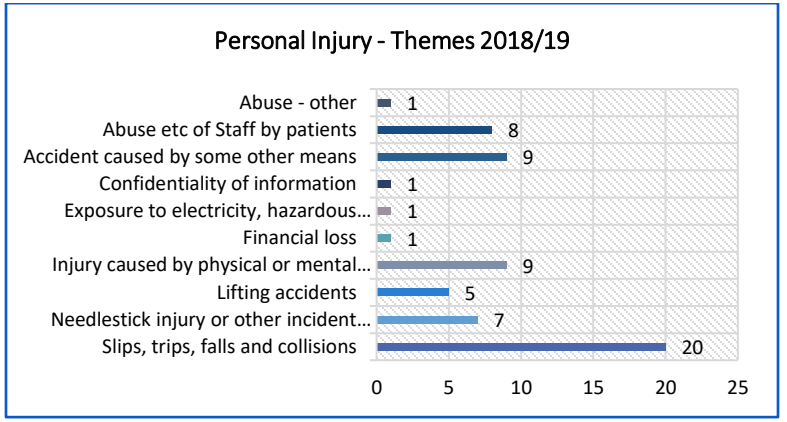
There have been a total of 282 new claims opened between 1st April 2018-31st March 2019.

Of the new claims opened 220 were Clinical Negligence and 62 were Personal Injury claims.

Of the 220 Clinical Negligence claims, the following themes have been identified during 2018/2019:



Of the 62 Personal Injury claims the following themes have been identified during 2018/2019:



CLAIMS

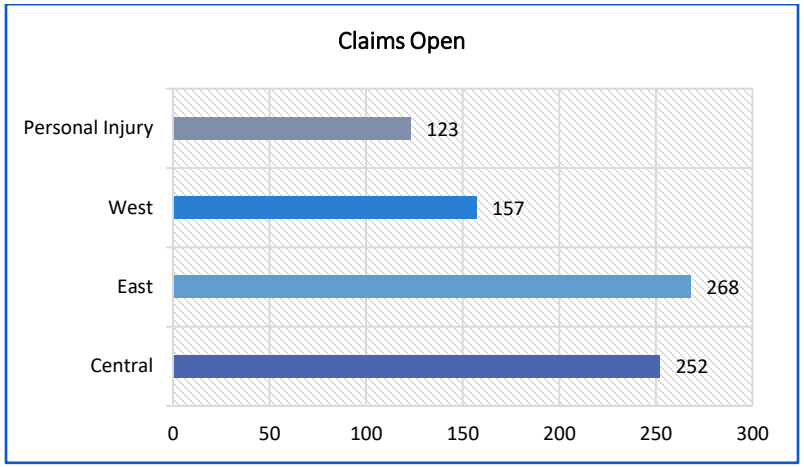
Comparison of Years

In recent years, the Health Board has witnessed a decrease in the number of new claims opened, with a notable decrease in Staff Personal Injury claims.

Open Claims

There has been a decrease in the number of claims received by the Health Board in 2018/19. Improved data collection within the claims function is now in place to ensure accurate monitoring and to improving the quality of trends analysis.

There were a total of 800 open claims in March 2019.



*Those listed as west/east/central are clinical negligence claims

As would be expected the largest number of open claims related to Surgery, Specialist Medicine and Women's Maternal Care. This is not an unusual profile of specialties within the NHS.

CLAIMS

A change in working practice has been adopted in the West supported by the Welsh Risk Pool and has provided good results. This approach will continue to be rolled out across the Health Board. The new way of working in the West has allowed the Team to provide more detailed information on their cases:

Damages Paid – All Wales Trend Analysis

During 2018/19, the Health Board received 282 new claims and had a total of 800 claims open; a decrease of 12 and a decrease of 12 claims respectively on 2017/18.

Payments totalled £22,346,261 in damages and claimants costs and £1,051,205 in defence costs with the Health Board contributing £2,965,180 (£25,000 per case) in line with Welsh Risk Pool requirements.

The damages paid figure relates to all the cases open for the period. These cases may not necessarily be closed, as the Health Board may need to settle costs etc.

Below are details of payments over £1 million during 2018/19

Month paid	Financial Year	Amount £	Area
Jan	2018-2019	2,016,367.65	East obstetric claim
Feb	2018-2019	3,983,625.50	Central obstetric claim
Feb	2018-2019	1,677,109.25	East obstetric claim
Total		**7,677,102.40**	

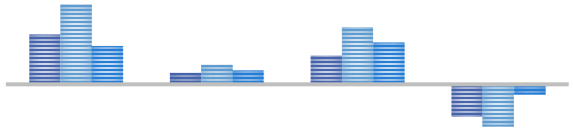
CLAIMS

Damages Paid

MEDICAL NEGLIGENCE (CASH PAYMENTS LOSSES EXC. REDRESS)

	Damages	Defence	BCU Contribution	WRP
2016/17	11,168,199.45	489,558.53	1,583,626.59	(10,074,131.39
2017/18	14,097,807.67	821,528.96	1,958,648.33	(12,960,688.30
2018/19	21,960,591.00	911,803.00	2,541,815.00	(20,330,579.00

PERSONAL INJURY (CASH PAYMENTS LOSSES EXC. REDRESS)



	Damages	Defence	BCU Contribution	WRP
2016/17	501,749.28	113,832.06	289,915.03	(325,666.31)
2017/18	808,368.30	194,285.47	576,766.13	(425,887.64)
2018/19	385,670.00	139,402.00	423,365.00	(101,707.00)

CLAIMS

Learning

Learning from claims and action taken is required to be evidenced to the Welsh Risk Pool once a claim is settled in an endeavour to reduce the risk of recurrence.

Examples of learning from concluded clinical negligence claims within 2018/19 include:

Failings identified	Action taken
Failure to diagnose fracture in ED	The orthodox method of scaphoid examination is taught to all new doctors starting in the ED. Since the time of this incident, we have also expanded the number and working hours of our Emergency Nurse Practitioners, who now see the majority of limb injuries attending the ED. Scaphoid examination is also specifically taught during their training. The usual method of scaphoid examination is also recorded in the Oxford Handbook of Emergency Medicine (several copies of which are available in the department). A one-day Minor Injuries course at YG last year. Consultant gave a talk on upper limb injuries in adults, with a specific focus on the injuries which are easiest to miss. (Copy of presentation attached) The practice is now that X-ray generate a list of examinations done for the ED each day and the receptionists mark off the reports as they arrive. After a week, they notify X-ray of any reports that have not arrived and these are then delivered. This was the product of months of effort and will reduce the number of abnormal x-rays which go unnoticed.

CLAIMS

Failings identified	Action taken
1. Incorrect interpretation of radiology images. 2. Equivocal radiology report not discussed in MDT meeting and Specialist opinion not sought before changing patient's care from curative to palliative	1. To be discussed in discrepancy meeting 2. Health Board to bring in Human Factors training 3. Lessons Learned Summary developed and shared with Clinical Leads
Careful use of diathermy during dissection of Calot's triangle and if possible the use of dissecting scissors	An audit on consents on patients undergoing laparoscopic cholecystectomy undertaken. Annual audit on laparoscopic cholecystectomy (elective and emergency) in terms of complications and return to theatre will be undertaken.
Claimant suffered a grade 4 pressure sore on her left heel as well as a sacral pressure sore which persisted until her death.	1. Nurses reminded of the importance of assessing all pressure areas on admission in order that appropriate action can be taken and patient's provided with the appropriate care, treatment and monitoring. 2. Audit to be undertaken to review the action taken with regards to the assessment and treatment of pressure areas following admission.
Failure to refer patient to liver centre following CT scan Failure to arrange follow up appointment following CT scan	To put a system in place to ensure results are reviewed and acted upon appropriately. Consultants are now encouraged to have a system in place to ensure results are acted upon in a timely manner. A log of all requests are kept by the secretaries and they are marked off as the procedures and performed and acted upon.

CLAIMS

Failings identified	Action taken
Twice appointments were delayed when should have been urgent	Papers relating to eye health care presented to Board outlining proposals for the future model to ensure improved eye care for patients Eye Care Measure an All Wales initiative introduced
Screening tests not done in GP Out of Hours Ophthalmology lost to follow up	Medical Advisor for West to include case in newsletter to ensure all clinicians aware that in rare circumstances to think of contributing factors to the presenting complaint such as e.g. diabetes in infected wounds. Papers relating to eye health care attached which have been presented to Boards outlining proposals for the future model to ensure improved eye care for patients Eye Care Measure an All Wales initiative introduced.

Key achievements in claims

The Executive Team for the Health Board now have a greater involvement in the financial approval of claims. A new process has been developed ensuring Executive approval is obtained on all claim payment and authority requests over £100,000.

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 weekly basis.

As mentioned above a change in working practice has been adopted in the West supported by the Welsh Risk Pool as part of an All Wales pilot which has provided good results. This approach will continue to be rolled out across the Health Board. The new way of working in the West has allowed the Team to provide more detailed information on their cases and they are able to provide accurate evidence of learning to the Quality and Safety Meeting.

WAY FORWARD AND CONCLUSION

Context

A significant amount of work has already taken place to address challenges in performance with increased scrutiny and challenge. The Concerns systems and processes have been reviewed on an ongoing basis, with the strengthening of the rapid review and of the Being Open approach improving the quality of investigations.

The further development of the harms dashboards has allowed greater viability of data and increased the opportunities for this to lead improvement and prevent further harms. Data is pulled from the Datix system.

The changes to the corporate and divisional teams to better support complaints and incident management is bedding in and will be key to supporting the culture of learning within the Health Board.

The Health Board is keen to reduce the need for people to complain, by learning and improving. The learning from complaints, incidents and claims is a continuous process of improvement with learning being shared locally, organisationally and nationally.

However should people have the need to complain we are also keen to improve people's experiences of the complaints process. In 2019/20 the Health Board will be introducing a regular system to gather feedback from complainants regarding their experiences and this will inform how we manage complaints moving forward.

The Health Board does however acknowledge that challenges still exist in relation to our systems, responsiveness and systematic learning.

Plan for 2019/20

A plan for 2019/20 is incorporated within the Annual Operational Plan. The Key Actions/ Deliverables in 2019/20 are:

We will make continual improvement in the management of concerns, specifically:-

- To reduce the backlog of complaints and incidents and establish real-time working
- To review the complaints and incidents processes to make them easier to implement for staff

WAY FORWARD AND CONCLUSION

- To further develop the model for organisational learning
- Conduct a training needs analysis in order to support the development of an effective training programme
- To gain feedback from complainants about their experience of raising complaints with the Health Board
- To rebrand the PASS service and rollout as PALs across the remaining area
- To further embed Being open and the principles of duty of candour
- To continue to build the harms dashboard to include patient experience data.