This is the third Annual Report produced by Hywel Dda University Health Board on the management of concerns, since the introduction of the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011.

This report outlines how the University Health Board has dealt with concerns received, for the period 1st April 2013 to 31st March 2014.

During the first quarter of the financial year, the University Health Board recognised that there were significant delays in providing timely responses to concerns and undertook urgent action to address this. From July 2013 the number of open concerns has reduced by 60%.

The introduction of the Patient Support and Advisory Service has been very positive. The number of queries and concerns dealt with by the service has increased each year. During the past financial year the service received 908 concerns, with only 17 of these needing to be passed to the formal concerns process. The University Health Board will continue to develop this service and continue to raise awareness amongst staff and members of the public.

The University Health Board is pleased to see a continuing reduction in the number of formal complaints being received. Since the introduction of the University Health Board in 2009, the number of formal complaints has reduced by 35%. In relation to the number of serious concerns received, this has reduced by 40% in the last 3 years.
OVERVIEW OF ARRANGEMENTS

Structure

All staff and organisations providing services on behalf of the NHS have a duty to comply with the aforementioned Regulations. However, specific roles in relation to the implementation of the aforementioned Regulations are as follows:

The Chief Executive has overall accountability for the implementation of the Regulations referred to above.

The Director of Corporate Services had delegated responsibility on behalf of the Chief Executive to ensure that there is a structure in place and supporting arrangements to ensure the effective management of concerns and redress processes. This responsibility will soon be changed to the Director of Strategy, Therapies and Health Science who will assume responsibility for the concerns and quality and safety portfolio.

The Assistant Director of Corporate Services and the Associate Director of Assurance and Safety are nominated Senior Investigating Officers, responsible for the handling and consideration of concerns. The responsibilities include the arrangement of suitable training for all staff.

The Putting Things Right Facilitator has a significant role in ensuring that all responsible bodies within the University Health Board area and members of staff are aware of the Regulations and the University Health Board’s arrangements for the management of concerns and reinforcing the Being Open principles. The post holder also acts as the Liaison Officer for the Public Services Ombudsman and co-ordinates/facilitates Ombudsman investigations and ensuring appropriate actions are undertaken to meet recommendations.

Directors, Assistant Directors and Heads of Departments are expected to ensure that investigations are undertaken into concerns within their area, appropriate responses are provided and to ensure that any lessons learnt as a result of investigations are identified and actions put in place to reduce the risk of reoccurrence. This includes the requirement to establish suitable processes to support the investigation of concerns and learning from events.

The Assurance and Safety Team are responsible for leading on Grade 5 Concerns, including support for the development of an action plan and offer support/guidance to investigating officers for concerns graded as 4 and below.

The Concerns and Redress Team are responsible for co-ordinating the investigations into all concerns raised; providing a point of contact for the complainant and ensuring the putting things right regulations are applied to all concerns received.
Process

All concerns (incidents, complaints and claims) are graded in terms of severity. The Patient Support Team initially grade complaint and claims, based at the University Health Board headquarters, on the detail provided in the concerns correspondence. Incidents are risk scored by the reporter at the time of submitting an incident on the Datix risk management system, by taking into account the severity and resulting harm sustained as a result of the incident.

The grade is quality assured by the investigator following further review of information and records.

The grading is carried out in accordance with the following National Patient Safety Agency categories of harm:

1 – Negligible
2 – Minor
3 – Moderate
4 – Major
5 – Catastrophic

In accordance with the approach to ‘investigating once, investigating well’, the depth of the investigation will depend on the grading and the complexity of the concern to ensure that the level of investigation is proportionate to the issues contained within the concern.

Concerns with a grading of 1-3 require a local investigation, led by the head(s) of service with support from the Patient Support Team/or the Assurance Safety & Improvement Team (ASI). This will usually be carried out by the Manager/Supervisor of the relevant department(s) and approved by the relevant General Manager in liaison with the Patient Support Officer based in each county. Incidents are approved by senior managers to ensure the completed investigation with lessons learnt are appropriate and any service improvements that are required are carried out. The investigation is not undertaken by any member of staff involved or named in the concern.

Grade 4 Concerns require a root cause analysis investigation and will be undertaken by a senior officer trained in investigation techniques and approved by the appropriate Assistant Director or equivalent. Support/advice is available from the ASI Team. The investigator will be nominated by the Senior Manager for the service.

Grade 5 (Catastrophic) concerns will be investigated by the ASI team, or if deemed to be in the best interests of the investigation, an external investigator will be appointed. Investigations of this nature will be approved by an Executive Director.
The types of investigation vary from concise to comprehensive or independent. As set out in the Concerns Regulations, the type of investigation must be proportionate and appropriate to the issues identified.

If it is alleged or identified that a patient has been harmed, as result of an act/omission by the University Health Board, the Board has a duty to investigate whether there is a qualifying liability. The matter is then referred to the Assistant Director of Corporate Services who may undertake further investigations and/or commission an independent expert report.

**Access**

**Training/Implementation of Regulations**

Training has been provided across the University Health Board on the PTR arrangements. Other sessions have been provided on writing appropriate concerns responses and the Being Open Process. Support is also provided to those who are undertaking nurse preceptorship training, new consultants and GP trainees.

Training and ongoing support is also provided to colleagues working in primary care practices, such as GPs, pharmacies, dentists and opticians.

**Information about the process**

Information is available in a variety of formats, including Braille and easy read and in a variety of languages. Information is accessible from the University Health Board’s internet site, which is regularly updated.

**Patient Support and Advisory Service**

We are pleased that the Patient Support and Advice Service (PSAS) which was first introduced in January 2012 has been very successful and is managing in excess of 900 concerns and enquiries per year. The service has made a significant contribution to the early resolution of concerns and has resulted in a reduction in the numbers of formal concerns being received by the University Health Board.

The role of the PSAS is to:

- Provide a service which offers a speedy resolution to concerns, as an alternative to raising a formal concern;
- Provide a service that is easily accessible and responsive to the needs of patients, their carers, family and friends;
- Act independently, addressing any concerns at the point of origin, helping to resolve patients concerns quickly and improve the outcome of care in the process;
- Provide confidential advice and support to patients, their families and friends;
• Provide accurate and timely information on local health services; and
• Support staff at all levels within the organisation to develop an open
  and responsive culture.

The University Health Board will ensure that this service is more
accessible to patients in each hospital setting and will implement plans to
have staff at each hospital.

Governance Processes

The Putting Things Right Committee reports to the Quality and Safety
Committee. The Committee is chaired by Julie James, Independent Member
and the Vice Chair is Mrs Sian-Marie James, Vice Chair of the University
Health Board.

The Committee provides assurance to the Quality and Safety Committee on all
matters related to complaints, compliments, incidents (collectively known as
concerns) and litigation across the Hywel Dda community. The Committee’s
key role is to ensure the statutory accountability of the Board in regard to
meeting the requirements of the NHS Concerns, Complaints and Redress
Arrangements (Wales) Regulations 2011. The Committee will also ensure that
any learning from events is shared across the organisation and primary care
contractors to improve quality of services and standards.

The Committee submits a report to the Public Board on a quarterly basis,
which identifies the concerns received for that period and provides assurance
on actions taken as a result of the issues identified.

CONCERNS STATISTICS

For the period 1
\textsuperscript{st} April 2013 to 31
\textsuperscript{st} March 2014 841 formal concerns were
received (957 were received in 12/13 and 1039 received 2011/12). 71% of these concerns were responded to within 30 days (this includes the
total number of concerns dealt with by the concerns team) and 89% were
responded to within 6 months.

For the period of 1
\textsuperscript{st} April 2013 to 31
\textsuperscript{st} March 2014 8547 (7713 2012/13)
patient safety incidents recorded. The number of incidents being reported
year on year is increasing and this is a positive cultural shift in the
identification and reporting of patient safety concerns by the staff.

The degree of harm (grading) of the concerns received are as follows:

<table>
<thead>
<tr>
<th>Degree of Harm</th>
<th>Complaints</th>
<th>Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (no harm)</td>
<td></td>
<td>3794</td>
</tr>
<tr>
<td>2 (minimal)</td>
<td>379</td>
<td>2904</td>
</tr>
<tr>
<td>3 (moderate)</td>
<td>407</td>
<td>1761</td>
</tr>
<tr>
<td>4 (severe)</td>
<td>41</td>
<td>20</td>
</tr>
<tr>
<td>5 (catastrophic)</td>
<td>2</td>
<td>68</td>
</tr>
</tbody>
</table>
The majority of concerns were notified to the University Health Board within 1 to 6 months of the event occurring.

During the year, the University Health Board has been making significant strides to resolve patient concerns at the enquiry/informal stage, without the need to initiate the formal concerns process. All contacts are recorded for monitoring purposes and to feed into the learning from events process.

In relation to complaints made by a third party on behalf of the patient:

- 78 concerns were received from the Community Health Council or other advocate;
- 44 were received from a solicitor/legal representative;
- 35 were received from an AM/MP; and

The specialities receiving the highest number of concerns (top 10) are as follows:
The graph below shows the main reasons for the concerns received:
Incident figures reported by service in the year 2013/14

The data in the graph below demonstrates the number of incidents by stage of care.
Patient Support and Advisory Service

During the year, the service assisted 909 patients or their relatives/advocates with their queries and concerns. Only 19 of these calls required escalating to the formal concerns process.

The following graph details the outcomes of the calls:
The following graph shows the top 10 specialties and the subject area:
Compliments

During the year, 138 formal compliments were received by the Chief Executive. This does not include the many compliments received direct to individual staff members, wards and departments.

Redress

Under the Regulations referred to above, the University Health Board has a duty to consider whether any failings identified amount to a “qualifying liability in tort”. This is where a person has suffered a personal injury or loss arising from a breach of duty of care that is owed to that person. A breach of duty of care is defined as being where someone has failed to act with the same reasonable care that would be provided by another person in the same circumstances, but also that the failure has caused significant harm. Where it is identified that some harm was caused, the University Health Board can offer Redress which includes a detailed response and explanation, an appropriate apology and information regarding actions which is being undertaken to minimize the possibility of a reoccurrence of events.

Of the cases received during this financial year 12 were dealt with under the redress arrangements.
The majority of cases dealt with related to A&E and orthopaedic specialties due to delays in diagnosis or missed fractures.

**Ombudsman Referrals**

During the year, the University Health Board received a total of 32 reports from the Ombudsman as follows:

- 9 were upheld;
- 10 were partly upheld;
- 3 cases were not upheld;
- 6 cases were not fully investigated by the Ombudsman as local resolution was agreed;
- In 2 further cases, a report was not issued and the complaint closed.

From the 9 upheld, one case was issued as a section 16 (public interest) report and was published on the University Health Board’s internet site. This involved the care and treatment provided in an out of hours general practitioner setting.

The University Health Board has produced detailed action plans to ensure that the organisation learns lessons from the failings identified in the reports. These are monitored by the Putting Things Right Committee.

**INCIDENT REPORTING**

**Incidents by Severity**

<table>
<thead>
<tr>
<th>Severity</th>
<th>Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Harm</td>
<td>3794</td>
</tr>
<tr>
<td>Minimal Harm</td>
<td>2904</td>
</tr>
<tr>
<td>Short term harm</td>
<td>1761</td>
</tr>
<tr>
<td>requiring further treatment</td>
<td></td>
</tr>
<tr>
<td>Major disability requiring lifelong care</td>
<td>20</td>
</tr>
<tr>
<td>Death or as HIGH but with losses &gt; £5m</td>
<td>68</td>
</tr>
</tbody>
</table>

8457 patient safety incidents were reported during the year. The incident data by severity notes that staff are recording incidents when no harm has occurred, this identification of any potential hazard or near miss can be reviewed and investigated early to ensure robust safety processes are in place to prevent serious accidents happening. The term “incident” is taken to mean a hazard or near miss for the purposes of reporting and investigation
and staff refer to the “Policy for the Reporting of Incidents, near Misses and Hazards”.

The University Health Board remains committed to and continues to report patient safety incidents to the National Reporting and Learning System (NRLS) which enables patient safety incident reports to be submitted to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care. Patient Safety Incidents are any unintended or unexpected incident which could have, or did lead to harm for one or more patients receiving NHS-funded care.

INCIDENTS REPORTED TO THE WELSH GOVERNMENT
Section 9 of the PTR legislation clearly sets out the reporting requirement to the Welsh Government.
• Concerns requiring reporting to the Welsh Government are those which are defined as serious incidents. A serious incident is defined as an incident that has occurred during NHS funded healthcare which results in one or more of the following:
  • Unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;
  • A never event – although not all never events result in severe harm or death they are incidents which should not occur. (25 listed never events in total)
  • Events that prevent organisations to deliver healthcare services
  • Loss of confidence in the service or adverse media coverage or public concern.

A total of 40 of these incidents were reported to the Welsh Government during 2013/14. During this period 1 never event was reported in regard to misidentification of patients. Never event details are published by “Patient Safety Wales” – Welsh Government website supporting NHS organisations to improve patient safety.

Mental Health & Learning Disability Services
Mental Health services capture their learning from incidents and aggregate the lessons and actions across into an overarching thematic action plan which is their framework to inform learning and practice change and also provides assurance to the Board.

The emerging themes within the strategic document are communication issues, training and educational needs; which have been identified from investigations from concerns identified from joint working with multi agencies, failure to support staff, service configuration, practice development the service user and carer information and engagement, risk management, crisis and contingency management.
Themed lessons learnt emerging from incidents by category and graded 1 to 3:

Operating department
Vigilance when typing names on documents is critical due to the impact when things go wrong.

Laboratory
Vigilance and care must be taken at all times when obtaining specimens from patients, transporting to the laboratories, and processing to ensure that patients do not need repeat sampling and prevent delays in treatment.

Pressure damage
Availability of airwave mattresses appears to be an issue at times; however, staff must be more vigilant at sourcing.
Staff to remember to ensure location needs to reflect where the incident took place and not the place of admission.

Assessment
When patients refuse their treatments/assessment and take own discharge ensure the records document the patient mental capacity.

Falls
Patients sustaining injuries must be reviewed and the outcome of the assessment must be documented in the immediate action.
For investigators it must be remembered that all outcomes of the fall must be reviewed and documented on the incident form.
All staff need to be reminded that a spinal injury assessment is part of the essential falls protocol.
The use of words such as ‘fair’ to describe observations does not provide assurance to the investigator due to the interpretation of what ‘fair’ means.

Abuse – Other & Physical Assault.
House visits should be risk assessed and where risks are identified managers should be made aware.
Patients/relatives must be reminded of the zero tolerance to any abuse.

Consent
When incidents refer to consent refusal, ensure that the Mental Capacity Test has been considered and documented.

Information Technology
Processes must be tested and improved to ensure patient safety is not compromised.

Self Harm & Absconders
Ensure all risk assessments are undertaken.

General
Staff to remember to ensure location needs to reflect where the incident took place and not the place of admission.
Incidents must be investigated timely to ensure that lessons are learnt and systems improved. Incident description must reflect the incident/concern. Ensure risk assessments are undertaken and documented.

Incidents graded 4 and 5
The investigations undertaken for concerns that have major and catastrophic patient safety issues at this level requires a full root cause analysis and the recommendations once approved by the service are converted into an action plan which is monitored by the service to ensure all areas are completed. The emerging themes are failure in the documentation for example failure to record a test result or record the time an entry is made in the clinical notes; communication for example failure to communicate between teams and failure to communicate information in a sensitive manor and failure to follow protocols.

CLAIMS MANAGEMENT

New claims
During the period 1st April 2013 to 31st March 2014 a total of 152 new claims were received, of which 130 were clinical negligence and 22 personal injury. There was a large increase in the number of new clinical negligence claims as compared with the previous year when there were 103 new claims. The number of new Personal Injury claims remains constant as there was the same number in the previous year. The second table shows a trend over time from July 2012 to March 2014 showing the number of new claims each month.

<table>
<thead>
<tr>
<th></th>
<th>Carmarthenshire</th>
<th>Ceredigion</th>
<th>Pembrokeshire</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Negligence former HA</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Clinical Negligence</td>
<td>65</td>
<td>15</td>
<td>48</td>
<td>128</td>
</tr>
<tr>
<td>Personal Injury - Patients</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Personal Injury - Public</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Personal Injury - Staff Hywel Dda</td>
<td>10</td>
<td>1</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Totals:</td>
<td>80</td>
<td>16</td>
<td>56</td>
<td>152</td>
</tr>
</tbody>
</table>
Open claims

As at 31st March there were 315 open claims, 278 clinical negligence and 37 personal injury (this includes 19 claims that are settled but not yet fully completed as not all the legal costs have been paid). 249 have been valued by solicitors acting on our behalf at £107.9 million. At the beginning of the year 212 the claims were valued at £76.8m. The increase reflects the higher number of claims and that a number of claims relate to high value cases relating to infants.

Closed Claims

52 settled claims were closed in the period and 60 were withdrawn. 26 of the settled claims had been settled in previous years and 26 were settled in the current year. In total 34 claims were settled in 2013/14 as 8 remained open awaiting settlement of costs. 10 claims settle in previous years also remain open while costs are negotiated.
Welsh Risk Pool

All claims to the Welsh Risk Pool were submitted within the required time of 70 days. The University Health Board is responsible for the first £25,000 of all claims.

The University Health Board received just over £5.8m from the Welsh Risk Pool in relation to 33 claims submitted for reimbursement.

LESSONS LEARNED

Hywel Dda University Health Board is committed to ensuring that remedial actions are undertaken and that lessons are learned as a result of concerns investigations and information/feedback provided via the Patient Support Service. This information is monitored at each level of the organisation and where a problem has been identified, service improvements are made.

The Putting Things Right Committee receives assurance information from county/directorate concerns operational groups which review all concerns and claims and monitor progress of investigations and implementation of action plans.

Learning from claims is a key objective and the University Health Board is required to demonstrate learning from claims when it submits claims for reimbursement. Common themes are supervision, competence of staff, training, record keeping and communication. The Legal Services Managers attend meetings and training sessions with clinical staff and managerial staff to ensure that appropriate feedback is provided on the lessons learnt from claims.

Over the year a number of initiatives have taken place which have resulted from the review of complaints. The following are examples of actions undertaken:

- Within mental health and learning disability services, following a series of falls on an older adult mental health unit a review of the data was undertaken, following which a pilot of a falls assessment tool was undertaken prior to dissemination. All falls are now discussed at multi disciplinary team meetings to ensure risks are identified and improvements made.

- General practitioners are now included at multi disciplinary team meetings to ensure all agencies have the most current history which informs any mental health risk assessments that need to be undertaken.

- Following failures in managing patients with diabetes a whole University Health Board action plan was devised and a series of educational sessions was provided to staff. The educational program was
developed based upon the audit feedback from questions devised by the clinical nurse specialists.

- The Butterfly Scheme has been rolled out and identifies and provides tailored care for dementia patients. More than 1,000 staff have been trained and the University Health Board is appointing champions on each ward to monitor and promote implementation of the scheme.

- The University Health Board has reduced the occurrence of a common infection acquired in the hospital setting (Cdifficile) in patients aged 66 and over.

- An orthodontic assessment service has commenced in order to reduce the waiting period from referral to assessment.

- Communication is the most common underlying cause across concerns. A service improvement project was established to analyse the issues arising from communication and a targeted training and improvement programme for specific areas has been introduced.

- In response to the concerns surrounding delays in radiology reporting, four radiographers were trained in skeletal reporting with further staff members identified for further training. The aim is to provide a network of reporting radiographers across the four hospital sites that will ensure at any one time that sufficient radiographers are available for reporting on A&E skeletal images.

- In response to the number of falls which take place in the hospital setting, a review was undertaken to identify the areas where frequent falls occur and work was undertaken in those areas to prevent and reduce harm from falls. A prevention of inpatient falls policy is being introduced, based on NICE clinical guidelines and work is ongoing in relation to the use of bed rails and low profiling beds for in-patient areas; falls preventative equipment such as mats/mattresses and movement alarm systems are being trialled; and additional training is being provided to support the introduction of the assessment and use of bed rails across the University Health Board.

- Following a concern about a breach of confidentiality a reminder was issued to staff relating to Caldicott and confidentiality principles.

- In response to an incident about a retained swab following an operation, the policy and procedure was reviewed and staff were reminded of the various processes and responsibilities involved.

- Following a concern relating to a long stay patient in ITU relating to communication and environmental issues, a letter is now routinely sent out offering a meeting with the patient’s family, 6 weeks post bereavement.
NEXT STEPS

During the next year, the University Health Board will focus on:

- Revising the concerns process to ensure that there is greater communication and engagement with people raising concerns throughout the process
- Working with directorates to improve the investigation and outcomes from concerns
- Further developing the investigation process and providing support and ongoing training to investigators
- Improve the access to and availability of information and support for patients with enquiries and concerns
- Further development of the patient support and advisory service, ensuring support is available on all hospital sites and within community