Aneurin Bevan University Health Board

Putting Things Right Annual Report

2018/2019

Contents

1 Introduction 3

2 Background 3

3 Complaints 3

3.1 Specialties Receiving the Highest Number of Complaints 5

3.2 Trend in Formal Complaints 6

3.3 Complaints Management 7

3.4 Examples of Learning from Complaints 7

3.5 Focus for 2019/2020 7

4 Serious Incidents 8

4.1 Description of Serious Incidents reported to Welsh Government 10

5 Never Events 11

6 Example of Learning from Serious Incidents associated with Patient Falls 11

7 Redress 11

7.1 Key Learning from Redress 13

8 Public Services Ombudsman for Wales (PSOW) 14

8.1 Key Learning from PSOW Cases per Division 17

9 2019/20 Focus and Priorities 19

1 Introduction

This report provides a summary of activity for the year 2018/19 in respect of the requirements set out in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (Putting Things Right).

2 Background

The underlying principle of Putting Things Right (PTR) is that whenever concerns are raised about treatment and care, whether through a complaint, claim or clinical incident, those involved can expect to be dealt with openly and honestly, receive a thorough and appropriate investigation, a prompt acknowledgment and a response about how the matter will be taken forward. The need to ensure that these principles are implemented as highlighted in the Evans Report*: A Review of Concerns (Complaints) Handling in NHS Wales* (2014).

Aneurin Bevan University Health Board has a well-established corporate team which manages complaints, clinical incidents, and claims, both personal injury and clinical negligence, together with Ombudsman cases and Inquests. The establishment of such a team is in line with the regulations and in addition fits with the model of management as directed by the Evans review 2014.

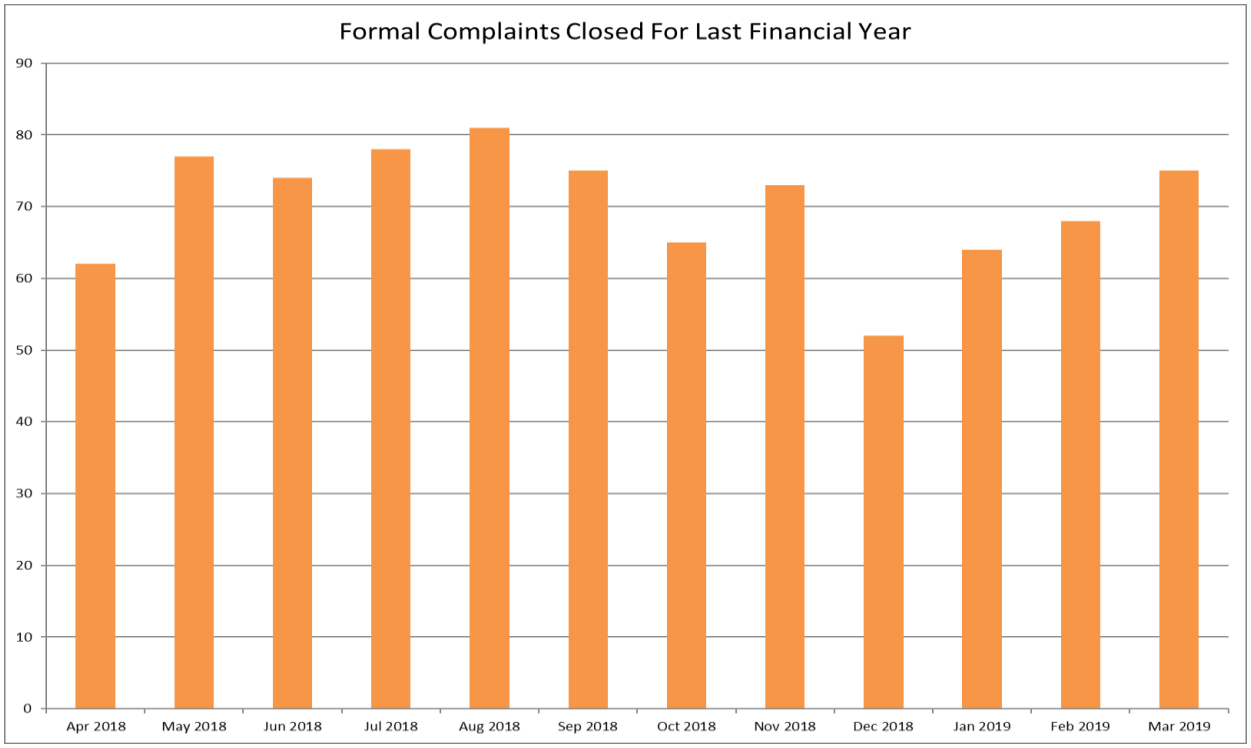
Staff in the Health Board are offered training in the management and response to concerns and information is accessible to all staff via the intranet and for patients and families via the internet with information about how to raise a concern, with links to the Putting Things Right Team. Patients raise their concerns via email as well as by post, telephone and in person.

The PTR team provide regular reports to the Quality and Patient Safety Committee that reports to the Board which sets out activity, analysis and learning.

3 Complaints

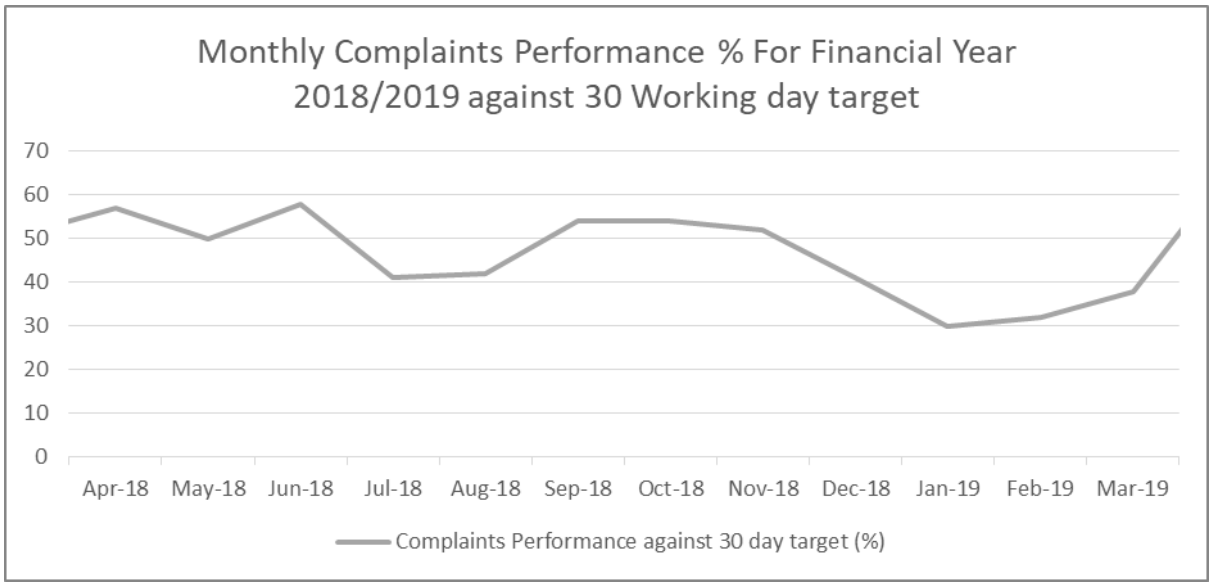
The number of formal complaints closed for the last financial year 2018/2019 was **844**. Graph 1 illustrates the number of complaints closed each month. The numbers were relatively consistent, with a slight decrease in December, which is attributable to the Christmas period.

Graph 1:



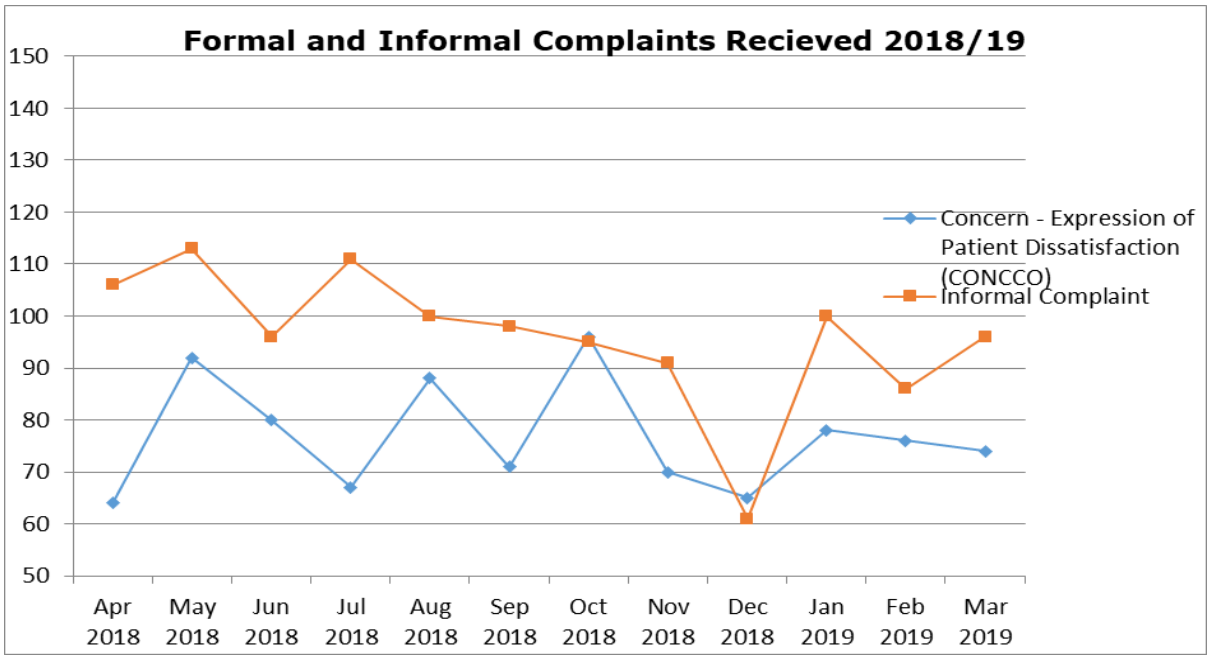
Graph 2 illustrates the monthly compliance against the 30 working day target of 75%. A priority going into 2019/20 has been improving the response timeframes. It is important to note that as indicated in March 2019, compliance increased and this has been sustained.

Graph 2:



During 2018/2019 the Health Board received **921** formal complaints and **1153** informal complaints, which is a slight decrease in formal complaints but informal complaint has risen slightly from 2017/2018.

Graph 3:

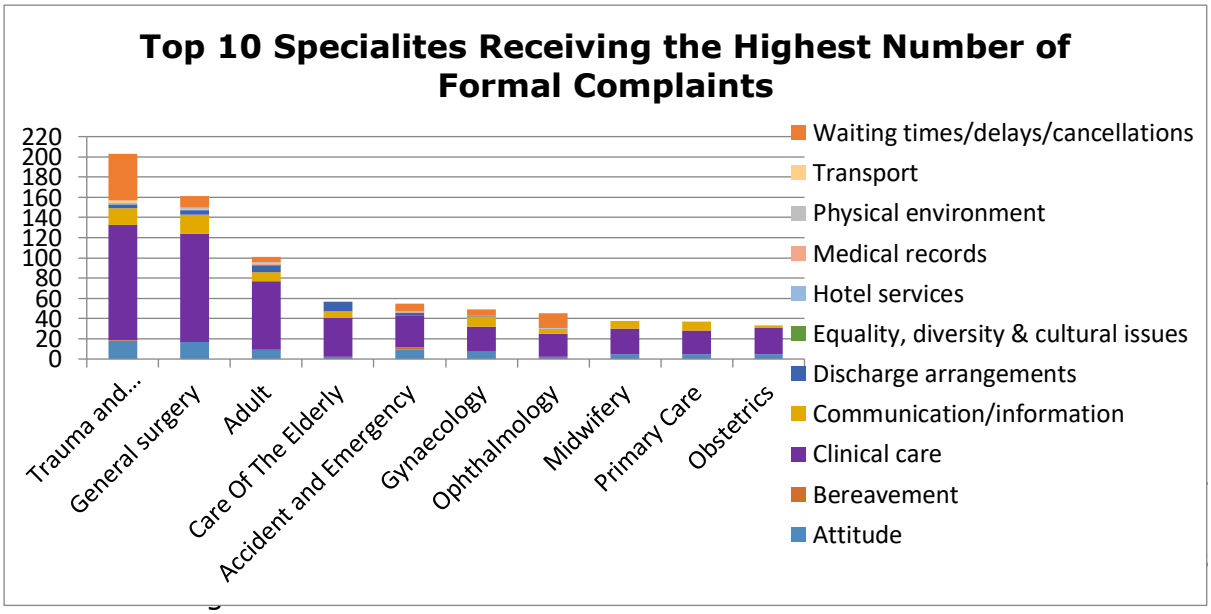


There are however, to be amendments to the PTR regulations which will change from May 2019. Complaints will no longer be classed as informal. All complaints will be formal unless the Health Board manages to resolve this within 24 hours and this will be classed as an *'Early Resolution'*. This is a Welsh Government requirement.

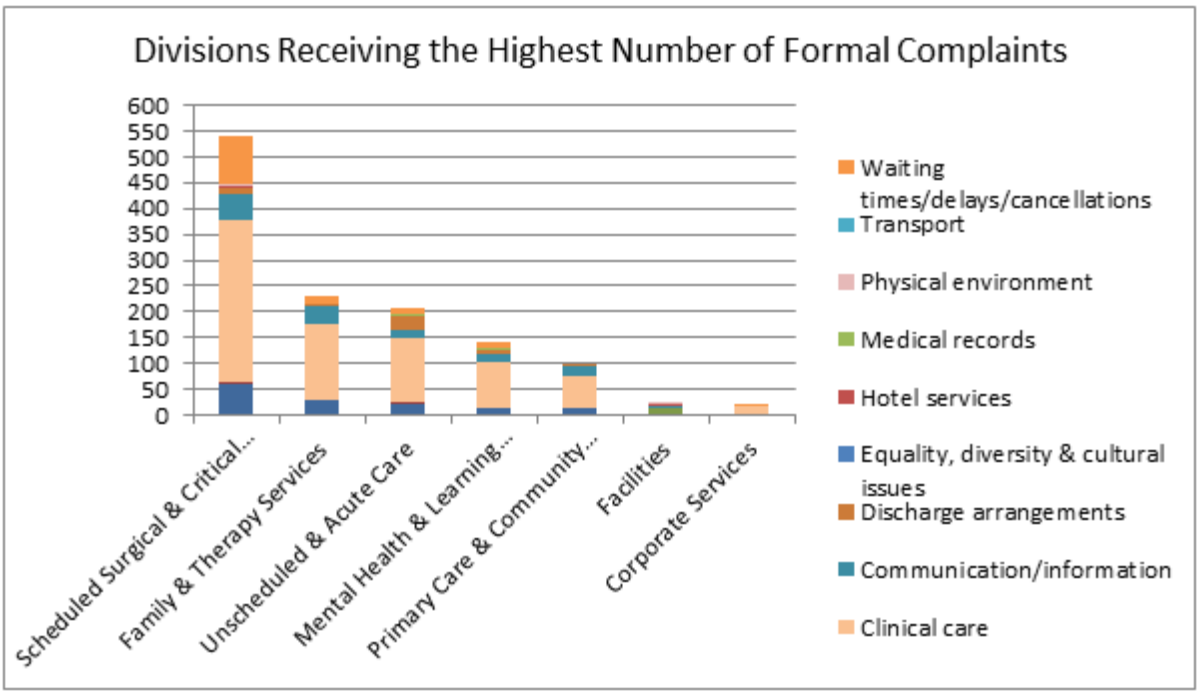
3.1 Specialties Receiving the Highest Number of Complaints

Graph 4 shows the top 10 specialties that have received the highest number of complaints during 2018/2019, together with the subject of those complaints.

Graph 4:



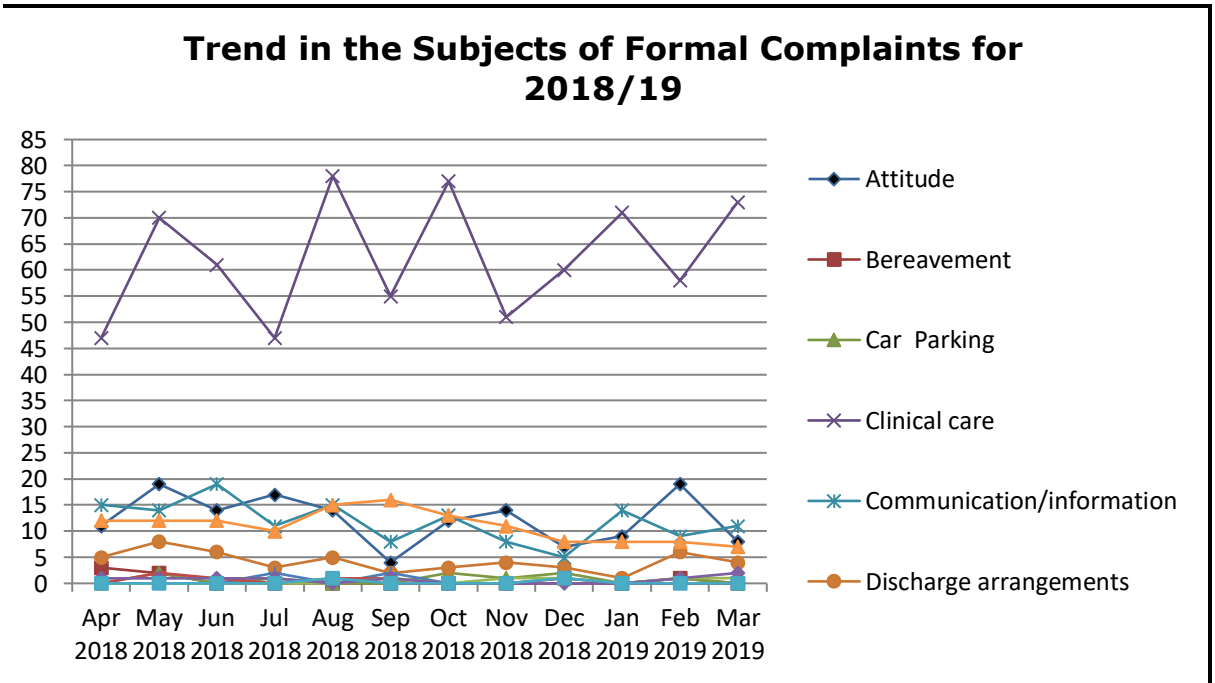
Graph 5:



3.2 Trend in Formal Complaints

Clinical care is the most reported complaint subject for 2018/2019, as it was in 2017/2018. The trend in the subjects of complaints during the year is shown below. Clinical care is a broad category and each Division reviews the detail of concerns to inform learning.

Graph 6:



3.3 Complaints Management

Central to the concerns process is the complainant and understanding the outcome required. Early contact with a complainant by telephone on receipt of concern is important and keeping the complainant updated with how the complaint is proceeding by regular communication either by telephone or a letter to ensure the complainant is aware that we are still looking into their concerns and advising where necessary what is causing the delay.

3.4 Examples of Learning from Complaints

During this this period there were a total of 2074 informal and formal complaints received. As identified previously these covered a number of themes. Key learning from this time included:

- Improving communication with patients waiting in the Emergency Departments at the Royal Gwent and Nevill Hall Hospitals.
- Informing the work plan for the care of patients with Dementia.
- Learning from an end of life concern has informed training and the development of the Bereavement Service.
- Learning from concerns informed the Winter Planning for 2019/20.
- Review of concerns relating to patient discharge informed improvement work with discharge arrangements and involvement of families.

3.5 Focus for 2019/2020

- Review the complaint process and improve response compliance. Each Division to set performance trajectories.
- Work to be carried out with Divisional leads / Senior Nurse's and complaints administrators in the management of concerns to implement the Service Improvement plan and provide a consistent approach and clear guidelines to achieving improved compliance against the 30 day target on complaint responses.
- Take forward further training for staff in the management and response to concerns.
- Further develop the outcome and learning framework.

4 Serious Incidents

Patient Safety Incidents are reported via an electronic database called Datix. This process is available to all members of staff and it is important that all staff are competent and confident to complete. A no blame supportive culture will allow for improvements to be undertaken, and fundamentally promote a safer environment and improved experience and quality of care.

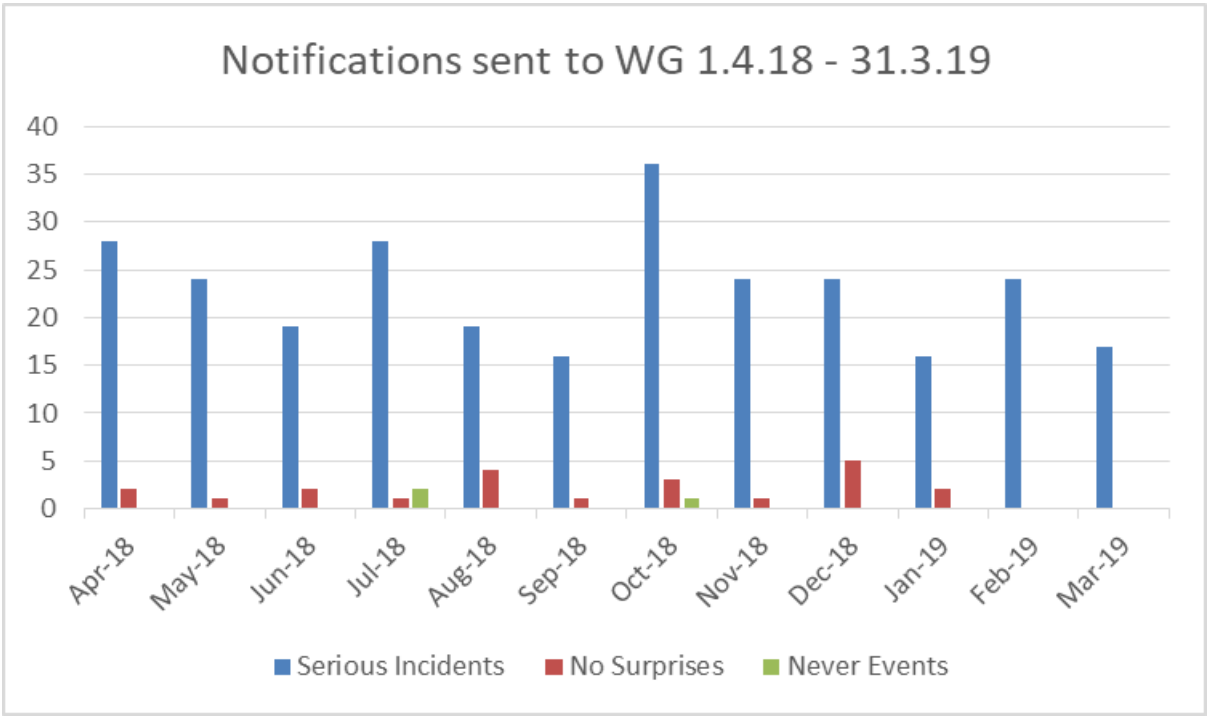
Any incidents which have caused serious harm to a patient is reported to Welsh Government (WG) and managed through a Serious Incident process. Additionally the following incidents also require reporting;

- Development of grade 3/4 hospital acquired pressure ulcers
- Clostridium difficile contributing to death
- An inpatient fall where a long bone fracture is sustained

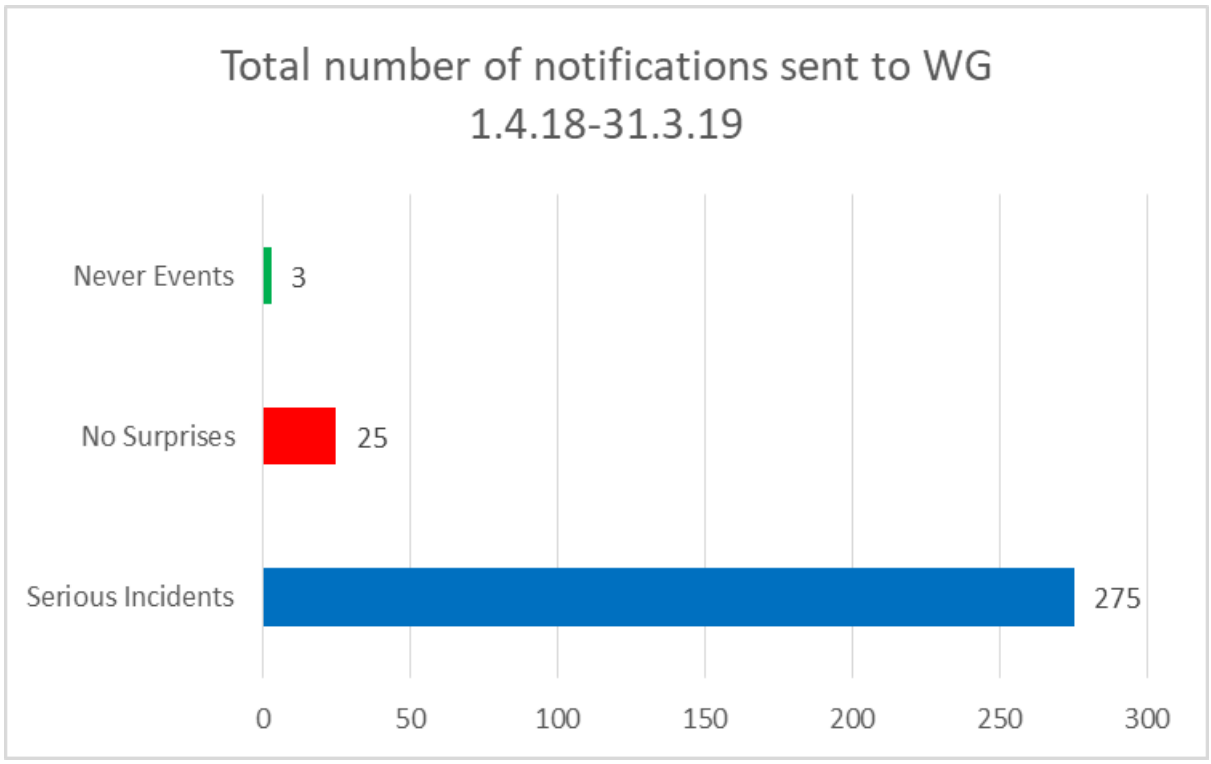
When incidents are reported to Welsh Government, a 60 working day timescale for completion of the investigation is provided. There is an expectation that families are communicated with and learning undertaken. Compliance is reported to Welsh Government.

Graph 7 and **8** provides detail regarding the number of notifications submitted to WG during 2018/2019, per month and a total over all.

Graph 7:

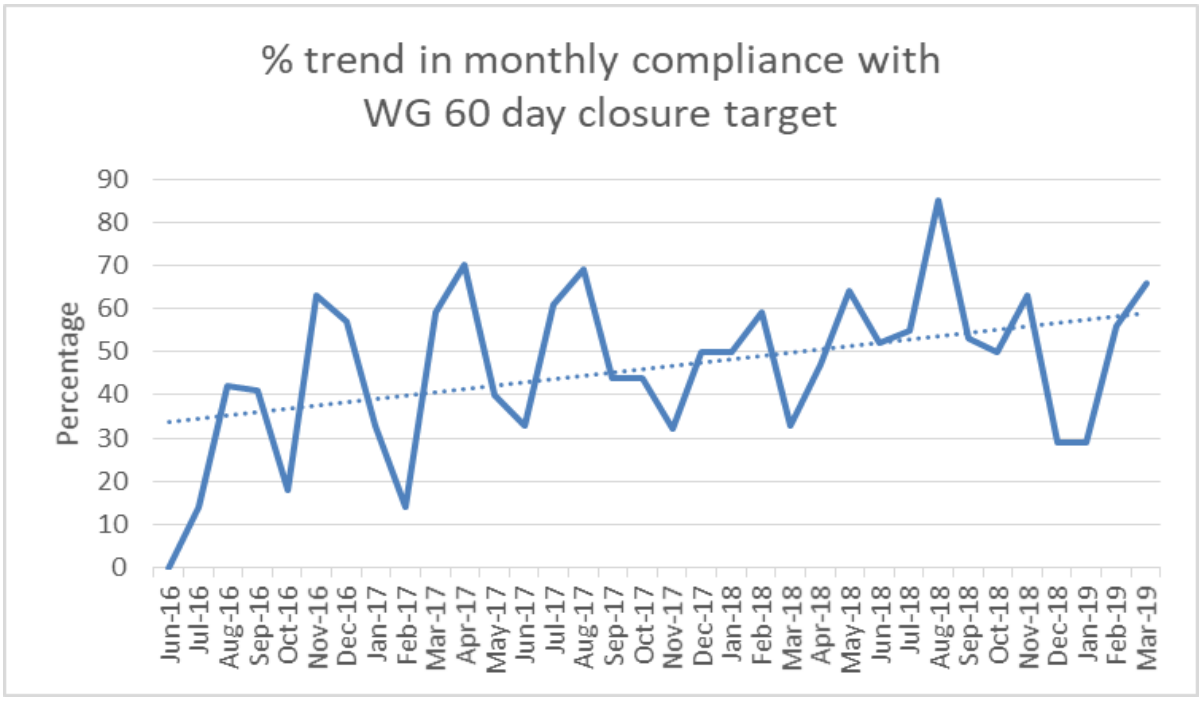


Graph 8:



Graph 9 illustrates the trend n monthly compliance against the 60 day closure target from June 2016 – March 2019.

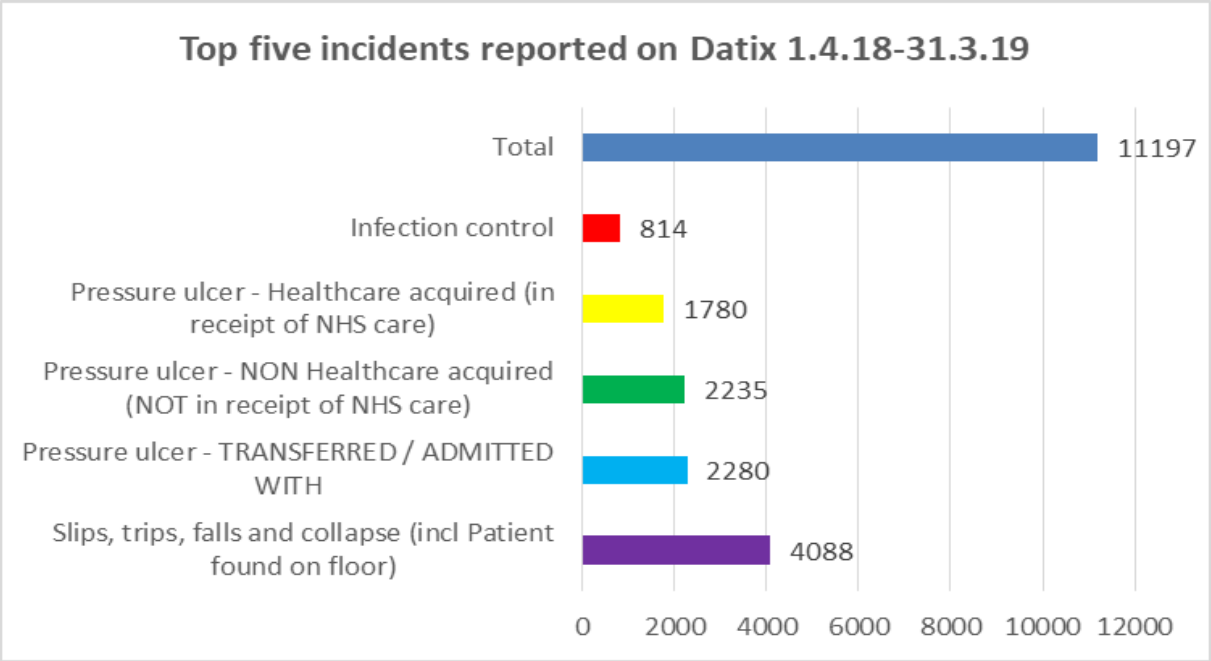
Graph 9:



4.1 Description of Serious Incidents reported to Welsh Government

Description	Number
Fall resulting in a fracture	53
Fall resulting in a head injury	10
Absconsion from ward	9
Infection control	26
Delay in treatment/diagnosis	12
Child admitted to adult mental health ward	11
PRUDiC (child death)	17
Pressure ulcers (grade 3,4 and ungradable)	62
Unexpected deaths including suspected suicides	56
Never Events	3
Other	16
Total	**275**

Graph 10:



5 Never Events

A 'Never Event' is defined as a serious preventable patient safety incident that should not occur and if available preventable measures should have been implemented. The list provided by the Department of Health currently describes 14 such incidents. It is imperative that root cause analysis is undertaken should such an event occur and that learning is implemented and shared.

During 2018/2019 three never Events were reported; these related to tooth extraction, lens insertion and retained vaginal swab. Following investigation remedial action was taken forward.

6 Example of Learning from Serious Incidents associated with Patient Falls

All serious incidents where a patient has fallen are reviewed by the Falls Steering Group. As a result of the review of incidents, the group led by the Executive Director for Therapies widened its remit to falls and bone health, in order to reduce the number of people that sustain a fracture when they fall. It is not always possible to prevent falls, and therefore improving the bone health of our population will reduce the risk of fracture, even if a person does fall.

The Falls and Bone Health Steering Group reviewed the Policy for Prevention and Management of Inpatient Falls to ensure it included all the learning arising from the review of falls incidents.

7 Redress

The underlying principle of the framework under which concerns are investigated regarding the care and treatment provided to patients albeit through a complaint or serious incident investigation is that those involved can expect those concerns to be dealt with honestly, receive a thorough and appropriate investigation. In addition the Health Board is also required to consider whether there has been a breach in our duty of care. The judgement of a breach of duty is based on the Bolam principles i.e. were the decisions and actions taken reasonable and appropriate as by judged by a body of "peers". If a breach of duty is agreed consideration then needs to be given as to whether that breach of duty caused harm. Where it is judged that the breach of duty caused harm there is a qualifying liability in tort and Redress needs to be considered.

Redress can mean:

- An apology
- Remedial action
- Explanation of the care given
- Compensation

The Health Board's Redress Panel heard **75** cases in 2018/2019.

Graph 11 illustrates the number of matters heard at Redress Panel since 2011/12 as per Financial Year. The decision are shown in Table 1.

Graph 11:

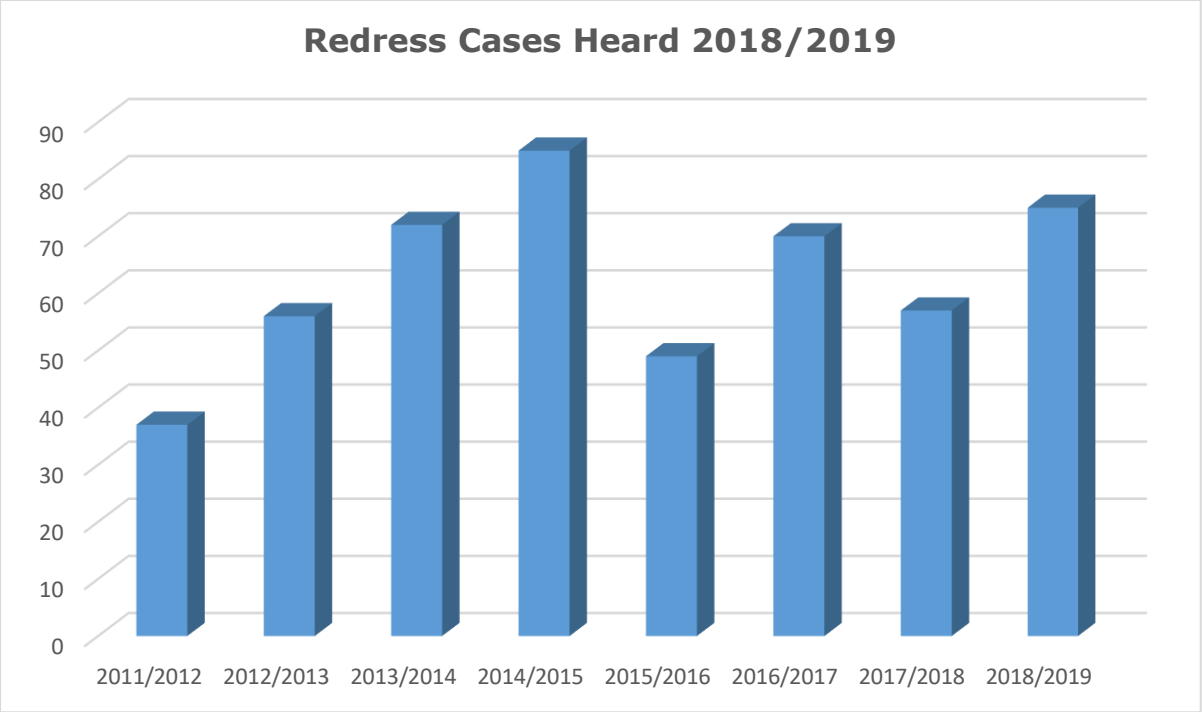


Table 1 provides details of the outcomes of the cases heard.

Table 1:

Number of Cases heard by Panel in 2018/2019	**75**
Of these:	
A qualifying liability was established.	61
A qualifying liability was not found.	14
The potential of a qualifying liability was found but due to the potential value exceeding £25k it was taken out.	Nil

7.1 Key Learning from Redress

Redress Panel has always been noted as a source of valuable, real time learning as the events in question are much closer in time to consideration of the matter than is the case in claims. This opportunity to learn and to ensure that this is undertaken is now considered in greater depth when cases are presented. The cases from Panel are also used to inform Health Board initiatives to address known issues e.g. in the case of pressure ulcers and the membership of the Pressure Ulcer Collaborative which has seen many positive results. Information was provided to the Panel on the demonstrable effects that the Collaborative on pressure ulcer reduction before and after implementation. The results were such that membership of the Collaborative is used to provide reassurance to the Panel and Welsh Risk Pool that active learning is taking place. Re-engagement with the Collaborative has been seen if further pressure ulcer cases are seen on wards where improvements have been made previously.

Often learning takes place through directorate or ward meetings where cases are anonymised and discussed for wider learning. Further learning outcomes are posted in the relevant departmental rooms describing the incident and reminding staff of the action needing to be taken.

Examples of learning and actions taken:

- Action from Panel – Discussions had with T & O around the delay of virtual clinic reviews to allocation of T & O appointment.

- Posters placed in department as a visual cue to go back to sepsis screening tool once blood tests received.

- Review of pharmacy process for checking patient's medication lists has been undertaken.

- Asthma watch list at NHH has been introduced and is being considered at RGH.

- New asthma chart for respiratory ward has been introduced with details management of patients with severe asthma. Asthma team in NHH is part of a UK wide audit which is live/ongoing. Data is captured on admissions including data surrounding the assessment of asthmatics, timing of drugs, escalation of care, duration of admission and follow up. The data will be looked at annually.

- Redesign of discharge lounge documentation has been undertaken to enable more accurate recording of pressure relief and patient's needs.

- Formal pathway for hip fractures in elderly people being developed to help determine whether further imaging by way of MRI scan or CT scan should be undertaken.

- End of life communication board introduced and has been incorporated into daily MDT meetings to ensure all end of life care patients are discussed and receiving appropriate pain management. Non-verbal pain management tool also introduced.

- Introduction of a traffic light system for patients at high risk of development of pressure ulcers and indicates how often patient needs to be re-positioned.

- Processes have been introduced with schedulers to facilitate more robust management of fracture patients requiring elective surgery.

- Signage to birth centre has been improved.

- Check before you collect initiative has been implemented in respect of food trays being provided to patients and the assistance required to patients.

- District nursing teams have been undertaking training in wound care modules and wound link nurse has been identified within teams.

- Checklist has been devised with is attached to the front of each patients notes under district nursing care ensuring that each nursing is undertaking assessments appropriately and timely.

8 Public Services Ombudsman for Wales (PSOW) Investigations 2018/2019:

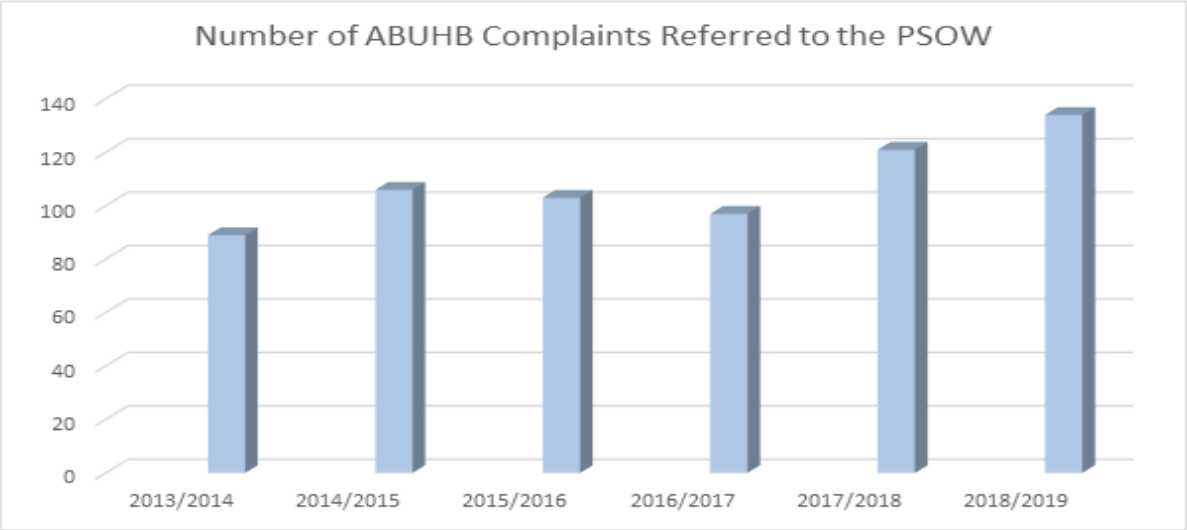
Close links between the Ombudsman's office and the Health Board have been maintained during 2018/2019 and positive feedback has been received in relation to the Health Board's response in dealing with complaints that have been referred to the Ombudsman. Regular meetings have been held with the Health Board's Improvement Officer and these have proved positive. In January 2019, the Ombudsman Improvement Officer attended a Complaints Workshop and presented information on complaints handling from the Ombudsman's perspective.

Throughout the year, there has continued to be Health Board representation at the Ombudsman Liaison Network, where issues of importance and interest are shared between Health Boards across Wales.

During 2018/2019 the Ombudsman received a total of **134** complaints in relation to Aneurin Bevan University Health Board. This represents a **10%** increase on the previous year.

Graph 12 shows the number of concerns referred to the Public Service Ombudsman for Wales over the last 5 years. This shows a year-on-year increase, which is also reflected in the number of complaints the Health Board has received.

Graph 12:



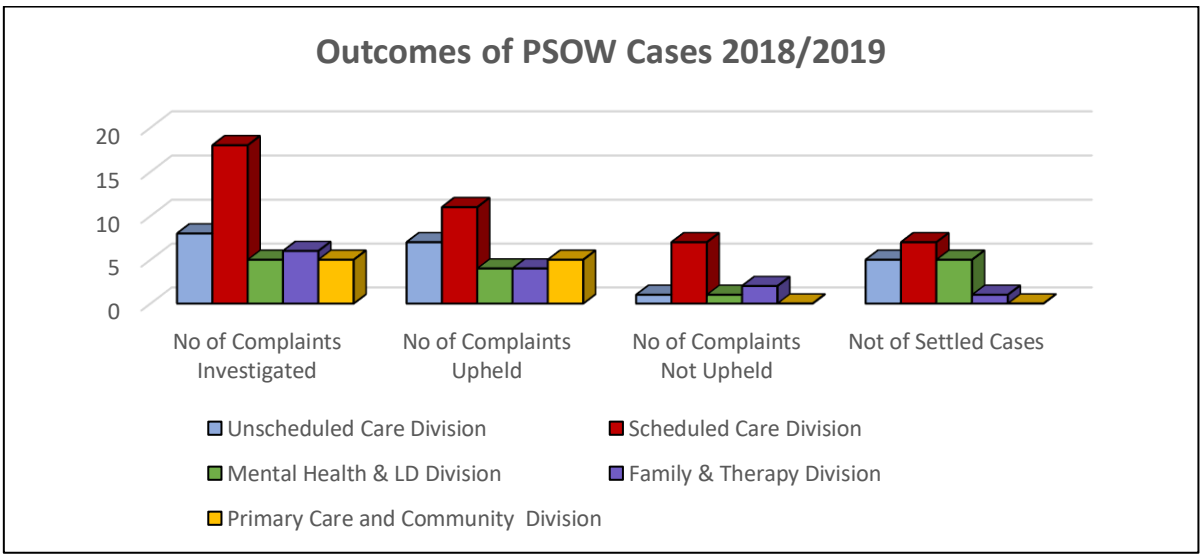
During this year, the Ombudsman investigated **42** complaints, which is consistent with the previous year. However, there was an increase from **17** to **31** in the number of complaints that were upheld and also an increase from **31** to **49** where intervention by the Ombudsman was necessary.

The Health Board undertook a detailed review of these cases to inform improvement work required.

During this year the Health Board received two Section 16 Public Interest Reports relating to care and treatment. This was of concern and the last time such a report was received was in 2014. As with all Ombudsman investigation reports, the Health Board has taken learning from these cases and the Ombudsman was satisfied that all recommendations were fully complied with.

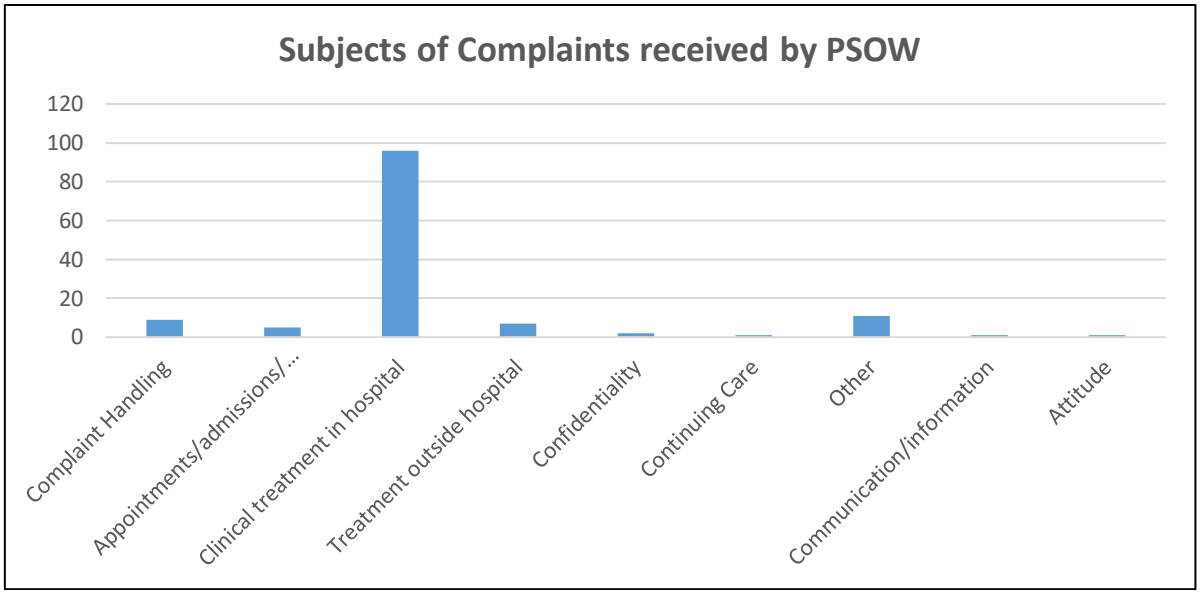
Working with the Ombudsman there was an increase this year in the number of cases that were able to be settled, avoiding the need for a formal investigation.

Graph 13:



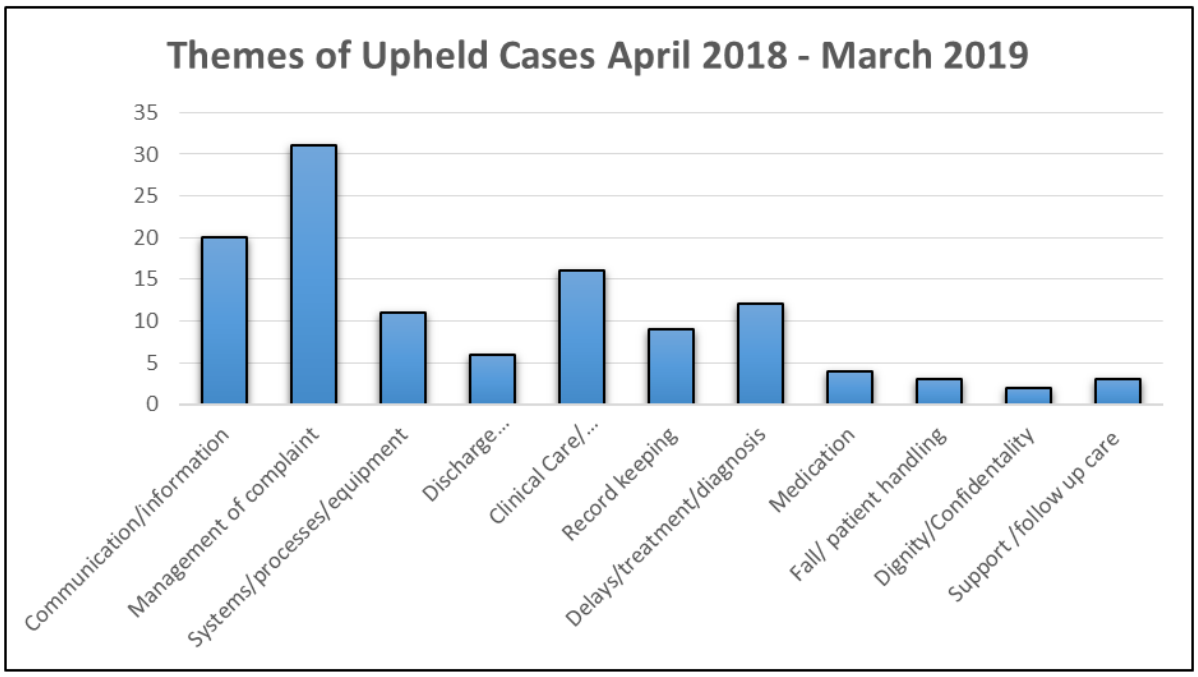
The subjects of the complaints received by the Ombudsman during 2018/2019 are shown below:

Graph 14:



A review of the subjects of the upheld cases during the year is broken down further and is shown below:

Graph 15:



As is shown in Graph 15, complaint handling is the most common theme and it is acknowledged that this is an area for improvement. As a result, the Complaints Workshop held in January 2019 provided representatives from each Division the opportunity to discuss the current processes and consider areas of improvement. Additionally, in the coming year training for Investigating Officers will continue to

be reviewed to ensure a consistent and effective approach to complaint handling across the organisation.

8.1 Key Learning from PSOW Cases per Division

As a result of Ombudsman investigations, during 2018/2019 the Health Board has acted on the recommendations to improve the services it provides. A great deal of learning has come from the Ombudsman investigations, and outlined below are the actions carried out this year by each Division:

Unscheduled Care Division has:-

- Provided evidence that systems are in place to monitor all aspects of nutritional care including compliance with nil by mouth status.
- Provided evidence that it has a process in place to ensure that ward staff have the necessary knowledge, skills and competence to provide care after death, including communicating with and supporting family members during this difficult time.
- At the RGH's Cardiology Unit action to ensure that, when there is diagnostic uncertainty, or the management plan changes, this is discussed with the patient in a telephone or face to face consultation wherever possible.
- Undertaken an audit to ensure that the relevant charts are properly completed in respect of the monitoring and assessment of pain.
- Carried out a review of its policies for day patients having procedures carried out under sedation.
- Developed a protocol for prioritising patients requiring coronary angiography.
- Reviewed the way in which chest examinations are undertaken and recorded for patients who have experienced a choking incident.

Scheduled Care Division has:-

- Undertaken a detailed review of its revised shoulder-scan protocol, with reference to:

  1. Clarifying and specifying the criteria for accepting shoulder-scan referrals in greater detail (so that GPs, in particular, know where and when to refer patients).

  2. Co-ordinating and integrating the use of US scans into the treatment pathway for patients with suspected impingement and rotator cuff tears.

- Reminded senior physicians at its Trauma & Orthopaedic Directorate of the need to ensure that patients who fail to respond to conservative treatment receive a consultant-led, clinical assessment and appropriate investigative scans in a timely manner.
- Revised the information provided to patients who are referred to other Health Boards and to introduce written policies and procedures for its nurse-led eye clinics.
- Reviewed its policies for day patients having procedures carried out under sedation.
- Reviewed and audited discharge planning documentation onwards.
- Undertaken a review of its process for keeping patients updated when treatment is delayed.

Mental Health and Learning Disabilities Division has:-

- Reviewed the procedure in progressing an application for funding to transition from female to male as a result of Gender Dysphoria1 ("GD").
- Provided training to all relevant ward staff, reviewed its policy relating to observation of patients and strengthened the sections on increasing and decreasing levels of observation.

Family & Therapies Division has:-

- Reviewed its (Dialectical Behaviour Therapy) DBT handouts to ensure they are appropriate for young patients with complex disorders.
- Reviewed communication with young patients in complex cases when multiple professionals are involved.
- Reminded staff of the importance of, accurate record keeping including in cases of fluid loss and reviewed its policy and procedures for paediatric pain management.

Primary Care & Community Division has:-

- Conducted an audit of facial surgery procedures. The audit examined and reported on the relative frequency of the use of local and general anaesthetic to ensure that decisions about anaesthesia are based on the clinical circumstances of each case and reflect established practice in this domain.

- Reviewed its practices to ensure that correspondence concerning patients is immediately available electronically for GPs to access.
- Reminded complaints team staff of the importance of providing timely and regular updates to complainants.
- Ensured that a process is put in place in relation to telephone consultations.
- Ensured all relevant staff are reintroduced to the current Wound Management Guidelines and reminded of the properties and appropriate uses of the listed dressings.
- Undertaken an audit to determine that all staff training on the Principles of Wound Management and the use of Aseptic Non-Touch Technique ("ANTT") for all wound dressing changes is up to date.
- Ensured that it has robust handover systems in place at both the District General Hospital and the Community Hospital for arranging patient transfers, to ensure that WAST is fully informed of the patient's condition when they are moved between settings.
- Arranged refresher training for District Nursing staff in relation to the measurement and recording of wounds, wound management and the auditing of care plans to ensure they are in keeping with national guidance.
- Taken forward further training in relation to falls prevention and appropriate use of bedrails.

9 2019/20 Focus and Priorities

The principles of a timely, honest and thorough response to a concern is fundamental. Recognising performance during 2018/19 key focus for the coming year relates to: -

- Improvement in the timeliness of response to complaints.
- Taking forward further training in both concerns and serious incidents investigations.
- Improving the quality of response to complaints and communication.
- Further developing the Learning Framework and emphasis on learning and continuous improvement.