Putting Things Right Annual Report 2019 - 2020

TABLE OF CONTENTS

Introduction ____ 4

Challenges and Successes 2019/20 ____ 6

Complaints / Concerns ____ 6

Serious Incidents (SI) ____ 10

Public Service Ombudsman for Wales (PSOW) ____ 23

Compliments ____ 27

2019/20 – Learning through themes ____ 29

Improvement actions for 2020/21 ____ 30

Aneurin Bevan University Health Board (ABUHB) 2019/20 in a nutshell

1658
Formal Complaints Received

238
Serious Incidents (SI)

140
PSOW Cases

82
Redress Panel Cases

Introduction

Whenever concerns are raised about treatment and care, through a complaint, claim or clinical incident, those involved can expect to be dealt with openly and honestly. These will receive a thorough, appropriate and proportionate investigation, a prompt acknowledgment with a response regarding how the matter will be taken forward, and importantly will identify lessons learnt for the future. This is the underlying principle of Putting Things Right, the regulations underpinning The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

As a Health Board we are committed to responding to concerns raised by patients, service users or their representatives, with openness and transparency and, where we can, learning from the concerns raised. Whilst it is disappointing to hear our services have not met expected standards, every concern provides valuable feedback and potential learning opportunities. Concerns provide a view, from a variety of perspectives, enabling changes and improvements to the services provided.

Aneurin Bevan University Health Board is striving to be a learning organistion, encouraging staff to develop and improve.

A learning organisation promotes a culture that encourages staff to: -

- Raise concerns and offer suggestions
- Challenge current practice without fear of blame or repercussions
- Feel part of a team
- Learn together

The ABUHB Putting Things Right Service has two main parts: Concerns (complaints) and Serious Incidents. Concerns are raised by people who have received services. Whereas Serious Incidents are predominantly raised by staff working within the service through the incident reporting system (Datix), where an unintended or unexpected incident could have or did lead to harm to patients.

If a person raising concerns is not satisfied with the concern response, they can refer the complaint to the Public Service Ombudsman for Wales (PSOW), who can offer a number of ways forward and are able to separately investigate the issues raised in the complaint.

Where the appropriate standards of care have not been met, and that has led to harm to a patient, the case is referred to the Redress Panel, who determine whether there has been a breach of duty of care and whether that breach of duty of care has caused harm. Redress can then be offered. Redress can take the form of an apology, explanation of the events that occurred, reassurance about the lessons learnt or, where appropriate, financial compensation.
The Putting Things Right (PTR) Service is co-ordinated by a central Corporate Team in ABUHB, the majority of the work to investigate concerns and serious incidents, takes place within the Divisions.

The production of the 2019/20 Annual PTR report has been unavoidably delayed as a result of Covid-19.

Table 1: *illustrates progress from 2018/19*

At the end of 2018/19, the focus and priorities for the coming year were identified as:	How did we do?	
Improvement in the timeliness of responses to complaints.	*Increase* from 41% to 63.5%	↑
Taking forward further training in both concerns and serious incidents investigations.	Face to face training scheduled for June 2020 – delayed until October due to Covid-19.	→
Improvement in the quality of complaint responses.	*Improvement* of 5.3% - cases upheld by PSOW *(2018/19 – 31/42 cases)* (2019/20 – 37/54 cases)	↑
Further development of the Learning Framework with an emphasis on learning and continuous improvement.	*Learning Events held* but impacted by Covid-19	↑

Challenges and Successes 2019/20

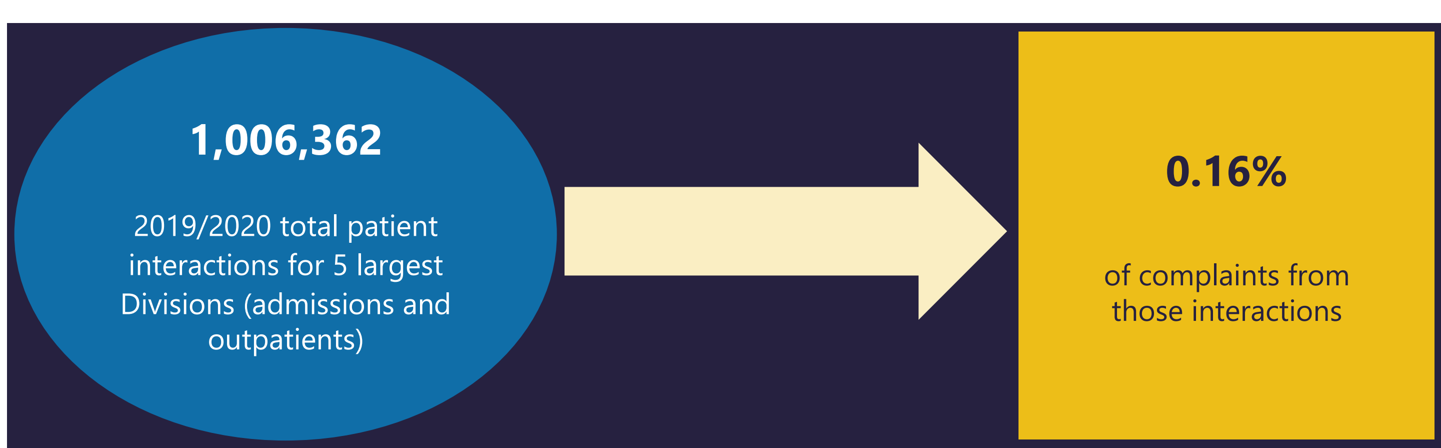
Challenges

- Consistent achievement of Welsh Government compliance target for timely concerns response.
- Quality of complaint responses.
- The majority of the PSOW upheld investigations showed dissatisfaction with the way in which the Health Board handled the complaint.
- Vacancies within the PTR team.
- Inability to deliver timely training for the Divisions regarding investigating concerns.

Successes

- PTR structure agreed and appointments made.
- Increase in Welsh Government compliance rates from 41% to 63.5%.
- PSOW reduction in payments in the last financial year.
- The development of Serious Incident Tools, which includes guidance notes for report writing, writing a Welsh Government closure summary and conducting an investigation.
- The introduction of huddles with PTR Team and Divisional Quality and Patient Safety Leads to identify any challenges and ensure that SI's and concerns are progressed seamlessly.
- Quality and Patient Safety (QPS) Leads are notified of an impending closure date 10 days prior to closure to ensure compliance.
- Improved use of technology and use of virtual meetings to reduce need for key clinical staff to travel, enabling better use of working time.
- Introduction of huddles with the Legal Team to ensure better communication around Coroners Cases/SIs.
- Quarterly meetings with the PSOW Improvement Officer, forging improved relationships.

Complaints / Concerns

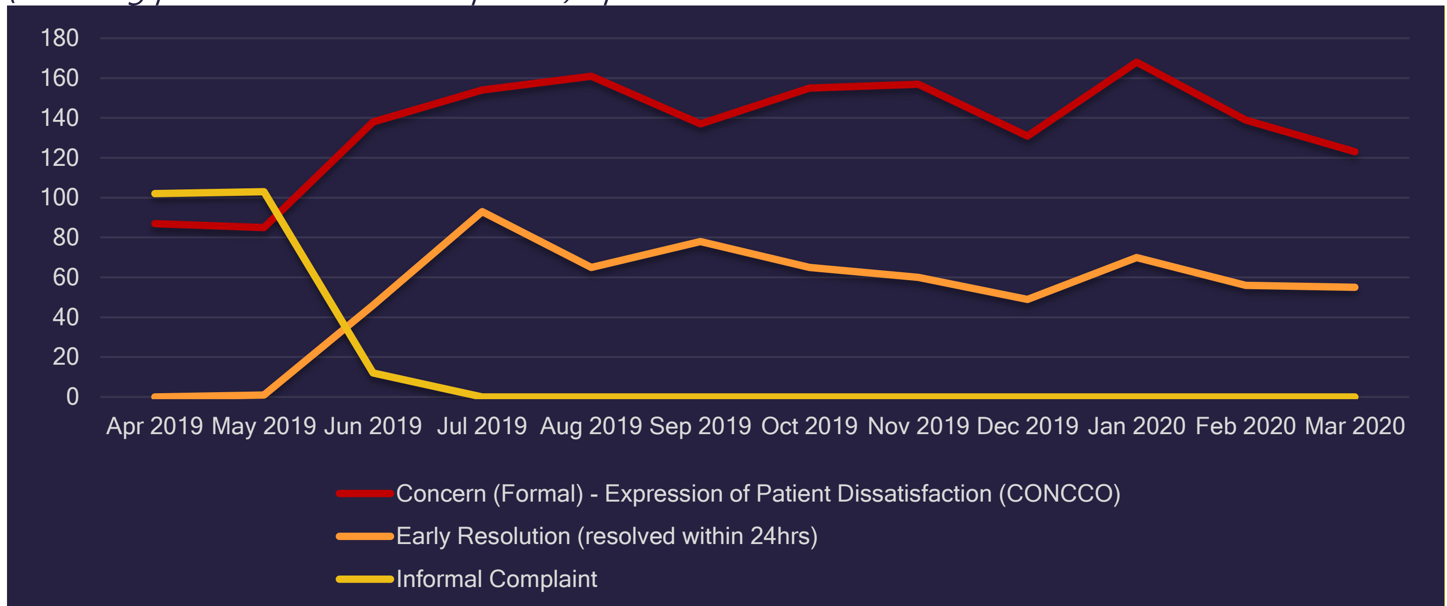


Each and every concern raised deserves, and is entitled, to receive an appropriate and proportionate investigation and response.

The large increase in formal complaints demonstrated in Graph 3, received from May 2019 onwards, is due to the change in the definition. Prior to this date complaints were categorised as either formal or informal complaints. The informal complaints were those, often received by telephone, resolved by the service looking at what had happened and responding within 5 days. Contact is made with the person complaining usually by phone, to explain what has happened and what is being done to address it.

Graph 1: *Trend in formal and Early Resolution*

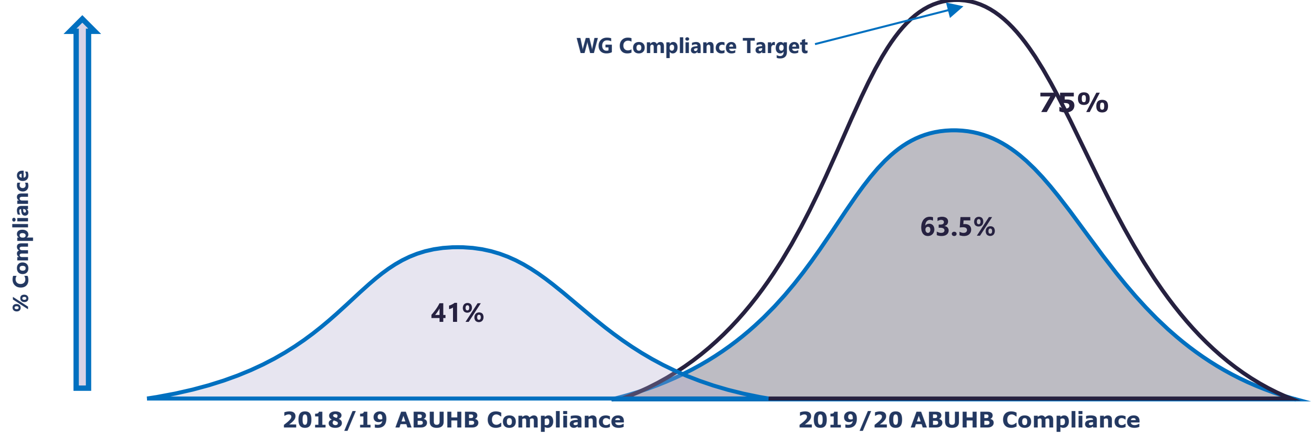
(including previous informal complaints) April 2019 – March 2020



Compliance with Welsh Government Targets

In 2019-20, ABUHB received 1658 formal complaints, 1568 complaints were closed in year, of which 995 were responded to within 30 working days, the Welsh Government target. Overall compliance for the year = 63.5% as illustrated in Graph 2.

Graph 2:

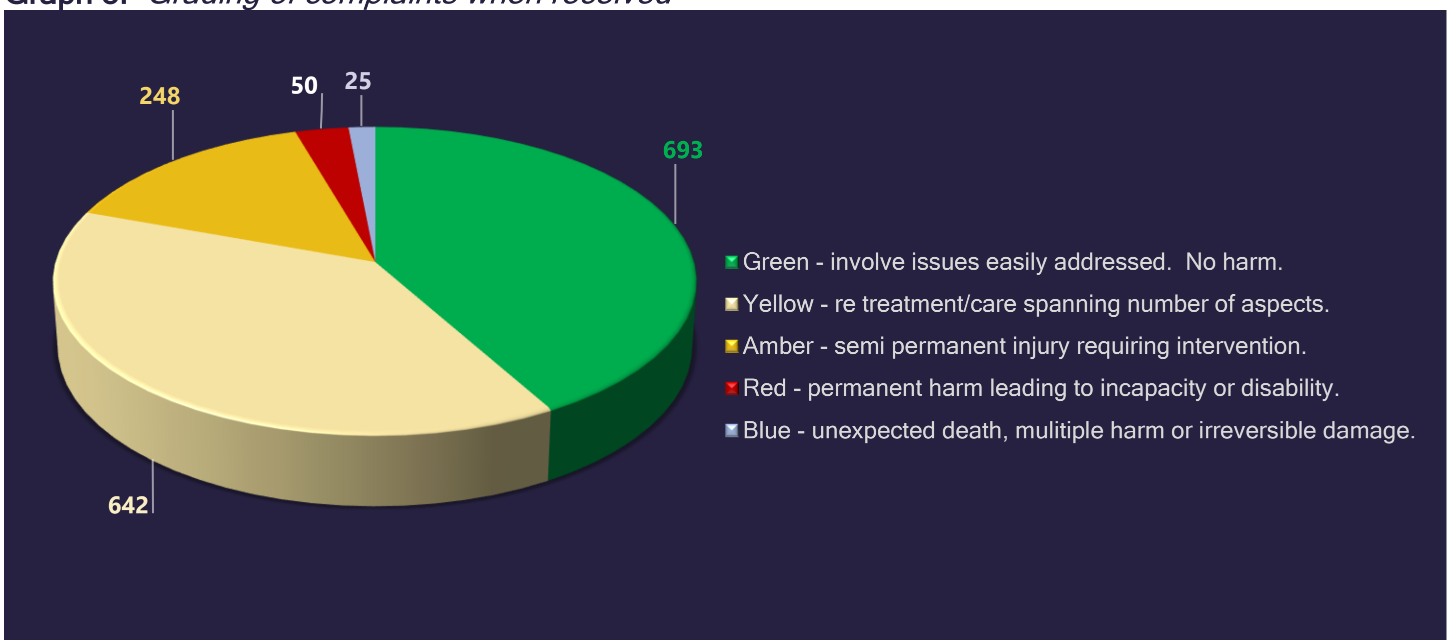


The Corporate Putting Things Right Team has worked with the Divisions, through improved training, networking, collaboration and sharing of best practice and consequently compliance has improved in comparison to 2018/19.

Table 2: *Guidance of Grading the Level or Harm in Complaints*

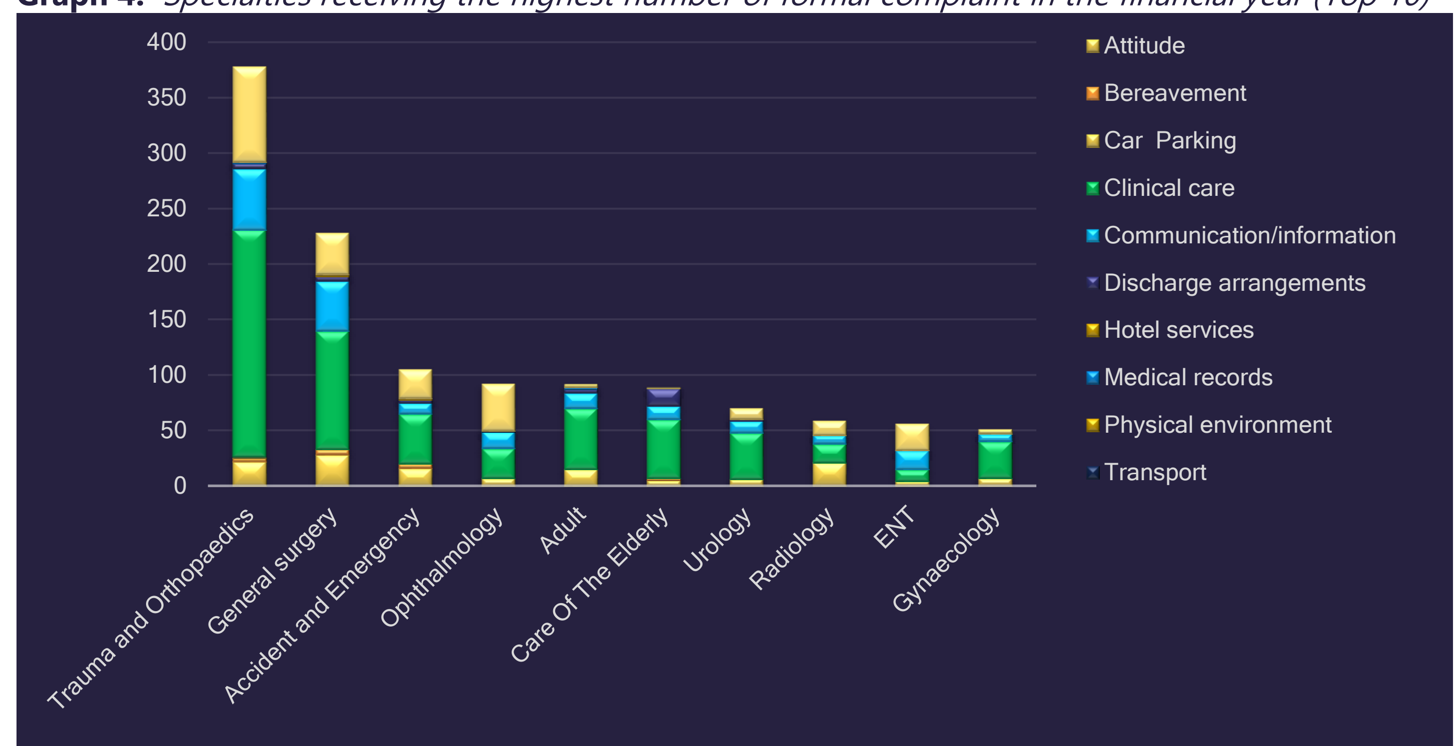
Grade 1	No Harm	No harm.
Grade 2	Low Harm	Minor implications for patient safety, patient fall requiring treatment, minor treatment.
Grade 3	Moderate Harm	Semi-permanent injury or impairment of health or damage requiring intervention, readmission, additional interventions.
Grade 4	Severe Harm	Semi-permanent harm leading to incapacity or disability, additional interventions, increased stay > 15 days.
Grade 5	Catastrophic Harm	Unexpected death, multiple harm or irreversible health effects, avoidable loss of life.

Graph 3: *Grading of complaints when received*



Following thorough investigation, of the 75 complaints that were initially graded as a 4 or 5, only 10 remained at grades 4 and 5. Therefore 65 of the initial 75 categorised as having caused severe or catastrophic harm, were subsequently downgraded.

Graph 4: *Specialties receiving the highest number of formal complaint in the financial year (Top 10)*



Improving the timeliness and quality of complaint responses

The introduction of a Welsh Government Target and furtherance of network links and collaboration between the Corporate PTR Team and Divisions has led to a rise in compliance of more than 20% in comparison with 2018-2019. There has however been a period of time since 2018 that training in complaints handling and response delivered through PTR, due to PTR team workforce vacancies, has not happened. Bespoke training sessions have been rescheduled during 2020/21.

Even though formal training has not been undertaken learning has continued with the following examples highlighting where changes have occurred.

Learning from Complaints

End of Life Communication and Care

As a result of concerns raised regarding end of life communication, including those concerning clear treatment escalation plans/ceilings of care, a number of actions have been initiated:

- An End of Life Seminar including priorities and communication at the end of life and Advanced Care Planning was run in November 2019. This was attended by 127 staff. In addition staff have been offered communication skills training. This will enable the development of skills in engaging in difficult conversations, with both patients and their families, regarding palliative care and end of life pathways.

Documentation

- Introduction of 'One Patient - One Day' audits to provide a snapshot of total patient care and experience – devised for numerous reasons particularly to improve communication and documentation standards.
- Senior Nurses are undertaking weekly documentation audits across wards to monitor recording of patient fluid balance and food charts, as documentation standards have been identified as an issue.
- Scheduled Care Division implemented a Quality Focus Group with standardisation of documentation as an area of attention.

Mental Health and Learning Disabilities

A lack of diagnostic and aftercare services for adults with Attention Deficit Hyperactivity Disorder (ADHD), was identified and as such the person raising the complaint was invited to be part of a group developing the Health Board's service model.

Reduction in Pressure Ulcers (PU)

In response to concerns raised around healthcare acquired pressure ulcers and their management. A number of measures were introduced, which included the use of hybrid mattresses, revision of SSKIN bundles, physiotherapy engagement, PU classification training, a Pressure Ulcer poster was also displayed, which was reported favorably as good practice by the PSOW. It highlighted actions for consideration which included;

- Body map completion on arrival on the ward
- Completion of necessary documentation e.g. WATERLOW and WAASP tools

Along with ongoing care, that includes 2-4 hourly skin bundles, use of profiling bed to reposition the patients also ensuring clinical photography and referral to Tissue Viability Nurses if required.

Serious Incidents (SI)

A Serious Incident is defined as; "an event which has involved either an act or an omission in relation to NHS funded care which has caused an adverse outcome, resulting in severe or permanent harm or death."

All Serious Incidents are reported to Welsh Government and managed through the Serious Incident Process with a target to be reported, investigated and learning identified within 60 working days of the incident notification.

In January 2020, ABUHB changed the way in which it categorised serious incidents and divided these into two separate categories. Serious Incidents are broken down into two criteria, Red 1 and Red 2 as illustrated in the following flowchart.

SERIOUS INCIDENT PROCESS DO IT WELL DO IT ONCE

A serious concern occurs

→ Division to ensure immediate patient safety actions are addressed with pace

Division report incident via **DATIX Web 'Serious Incident'** option selected. **Corporate Serious Incident Team** to be contacted on 01633 431671/431669 or x51671/51669.

Incident reviewed by Putting Things Right Team and advice sought from Clinical Executive Director/s, if required. Incident classified as **Red 1** or **Red 2**.

Welsh Government notified of the Serious Incident c.c. Executive Directors. Closure form to be completed within **60** working days.

CRITERIA FOR RED 1

Severe harm or death as a result of patient safety incident. Examples include:

- Coroner's cases
- In-patient suicide
- Sudden unexpected death in theatre
- Significant media interest
- Never events
- Complex multi-agency incidents

CRITERIA FOR RED 2

Significant harm as a result of a patient safety incident. Examples include:

- Management of deteriorating patient
- Medication incidents with harm
- Missed investigation results with harm
- Community Suicides
- Serious complaints with actual/potential harm

Directors to receive updates on Red 1 and 2 Serious Incidents via the Executive Clinical Huddle

RED 1

- An Executive or nominated deputy is allocated who will chair the review process, with full Divisional engagement.
- An Investigating Officer is appointed.
- 3 meetings are established.
- Draft Terms of Reference for the review are developed.

PTR Team arrange 1st SI Meeting
(1 week)

Purpose of meeting:

- Review incident and secure notes
- Agree Terms of Reference
- Support for staff
- Nominate lead contact for family/patient
- Assurance that immediate patient safety actions undertaken

Investigating Officer undertakes investigation and drafts investigation report
(6 weeks)

2nd Serious Incident meeting held within 8 weeks

- Review draft investigation report
- Identify learning and develop the action plan
- If Breach of Duty and Harm consider Redress Panel

3rd and final Serious Incident Meeting held within 10 weeks

1. Agree final draft investigation report and sign-off (if Non-Exec chair, the report will need Executive sign off)
2. Agree final action plan, monitoring arrangements and ABUHB learning
3. Confirm arrangements for sharing report with staff and family/patient
4. Welsh Government closure form completed by Serious Concerns Assurance Officer
5. Approved report and Action Plan to the Coroner

RED 2

- The Division will chair the review process.
- An Investigating Officer is appointed.
- 3 meeting dates are established.
- Draft Terms of Reference for the review are developed.

Divisional Team arrange 1st SI Meeting
(1 week)

Purpose of meeting:

- Review incident and secure notes
- Agree Terms of Reference
- Support for staff
- Nominate lead contact for family/patient
- Assurance that immediate patient safety actions undertaken

Investigating Officer undertakes investigation and drafts investigation report
(6 weeks)

2nd Serious Incident meeting held within 8 weeks

- Review draft investigation report
- Identify learning and consider the action plan
- If Breach of Duty and Harm consider Redress Panel

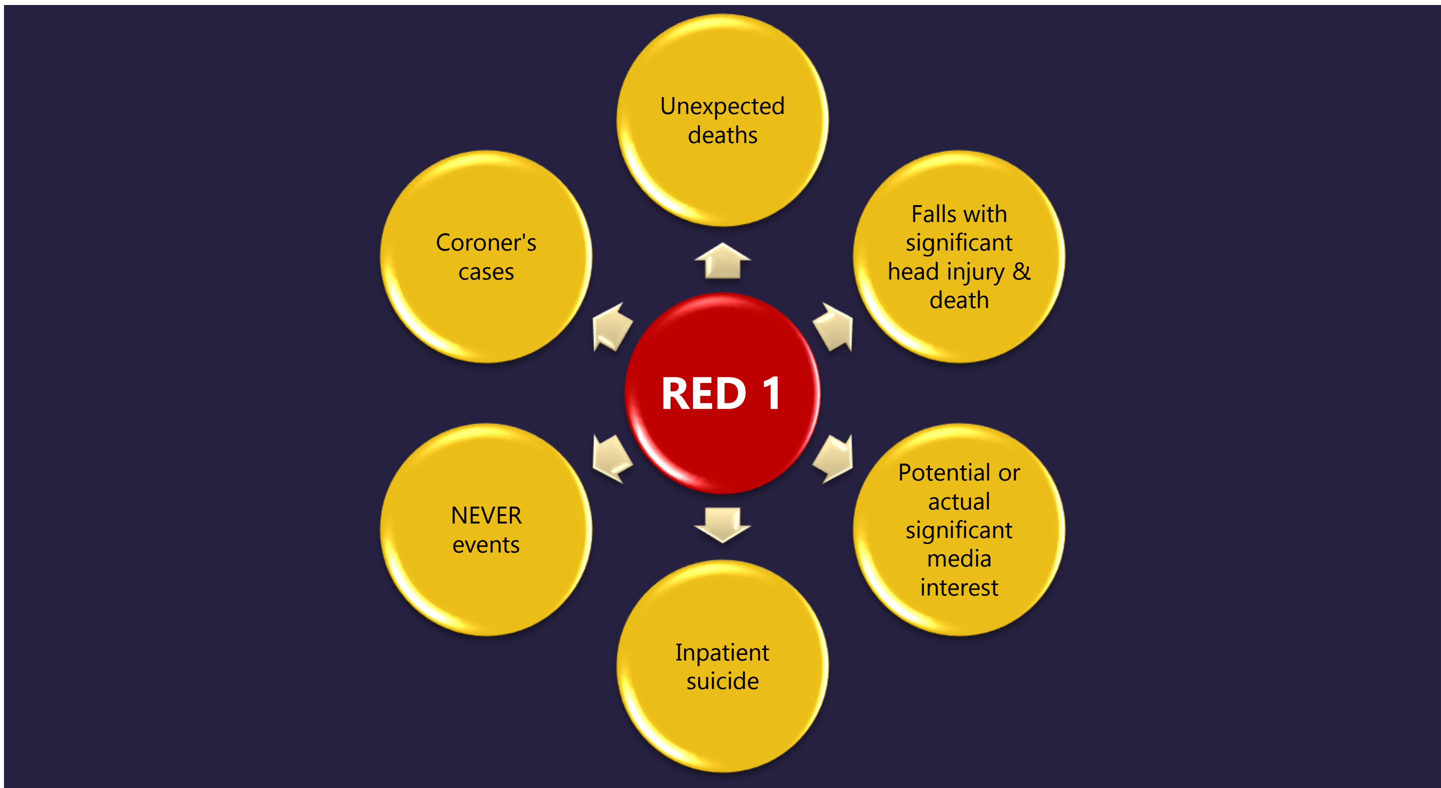
3rd and final Serious Incident Meeting held within 10 weeks

1. Agree final investigation report and arrange DD/GM/DN sign off
2. Agree final action plan, monitoring arrangements and Divisional learning
3. DD/GM/DN arrange Executive sign off via Concerns Team
4. Confirm arrangements for sharing the report with staff and family/patient
5. Case discussed at DQPS meeting
6. Welsh Government closure completed by Division and forwarded to Serious Concerns Assurance Officer

The expectation is that timescales are met and SI's are robustly, effectively and efficiently managed

Red 1: Serious Incidents

Formally known as Corporate Serious Incidents are incidents which have resulted in severe harm or death. Examples include:

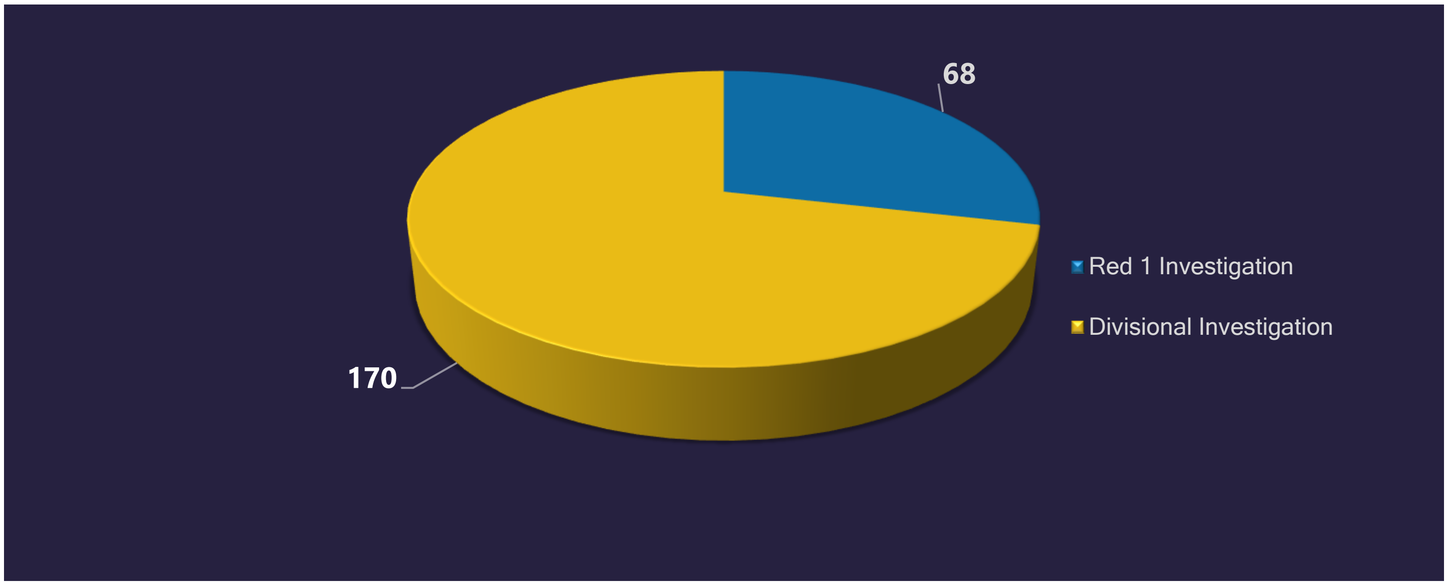


Red 2: Serious Incidents

Formally known as Divisional Serious Incidents are those that have resulted in moderate to severe harm as a result of a patient safety incident. Examples include:

The number of incidents reported to Welsh Government were either led by the Division as a Red 2 investigation or Corporate led as a Red 1. This equated to 71% and 29% respectively.

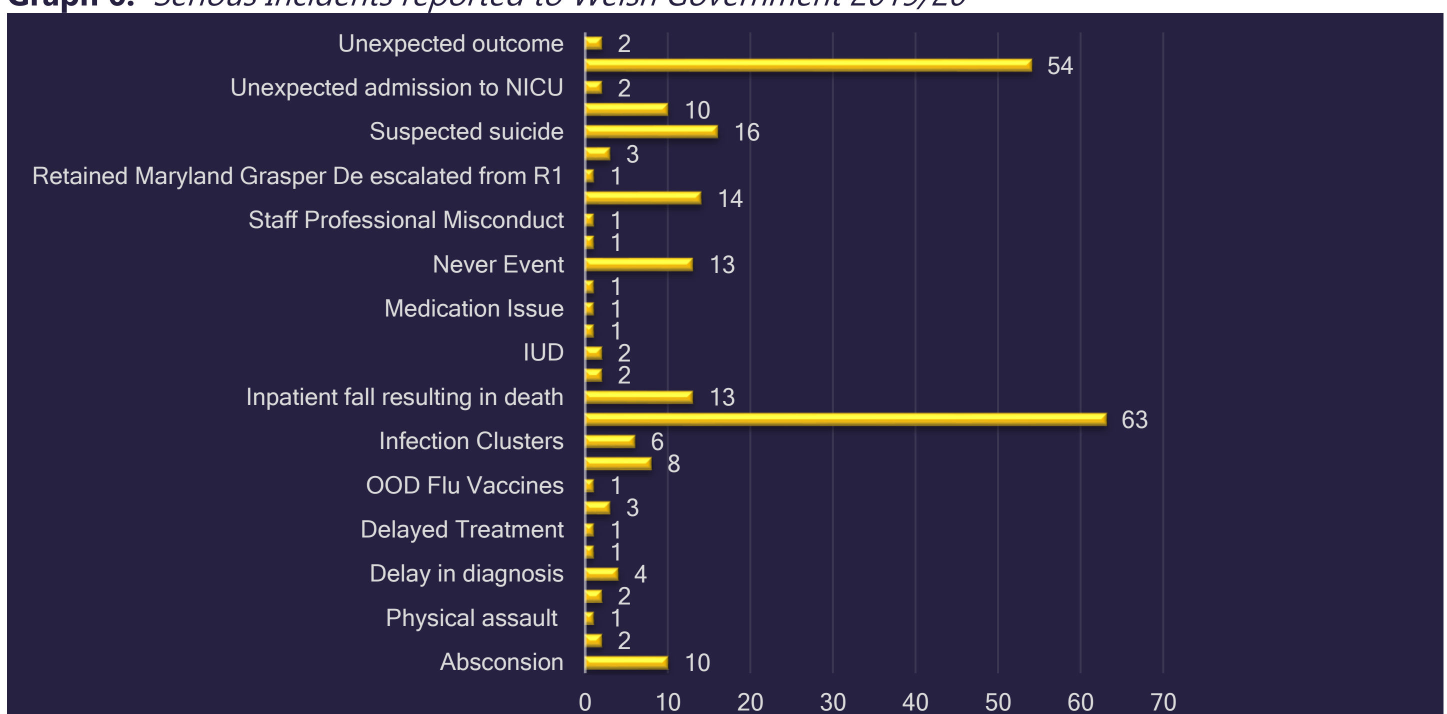
Graph 5: *Red 1 and Red 2 Investigations – 2019/20*



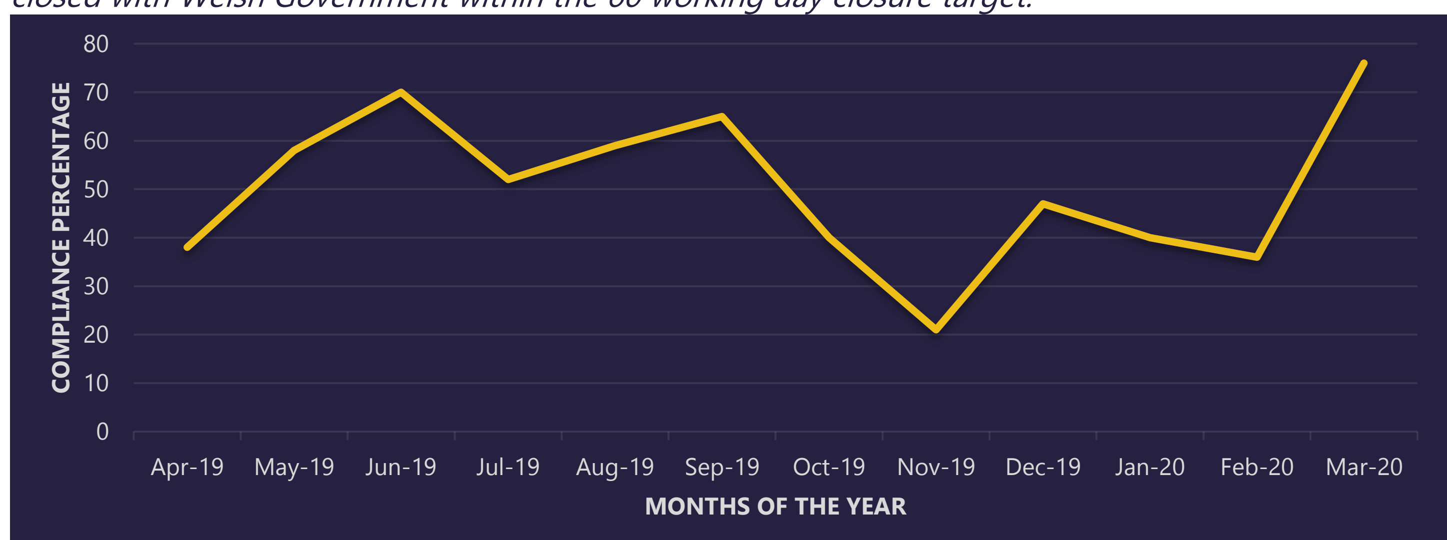
The following graph illustrates the criteria for reporting incidents, with the top three themes as follows;

1. Inpatient fall with fracture
2. Unexpected death
3. Suspected suicide

Graph 6: *Serious Incidents reported to Welsh Government 2019/20*



Graph 7: *shows the Health Boards compliance with serious incident investigations concluded and closed with Welsh Government within the 60 working day closure target.*



Serious Incidents – Falls

Inpatient Falls are reported as incidents on Datix. Many falls do not result in major physical harm for patients. A target was set in April 2017 to reduce the annual median inpatient falls by 10% over 2 years (in line with the recommendations in WHC (26) 2016). The actual median at March 2019 showed a reduction of 19% on that time period.

When comparing hospital sites, the number of inpatient falls (per 1000 bed days) is seen to be higher in those sites with single rooms i.e. YYF and YAB.

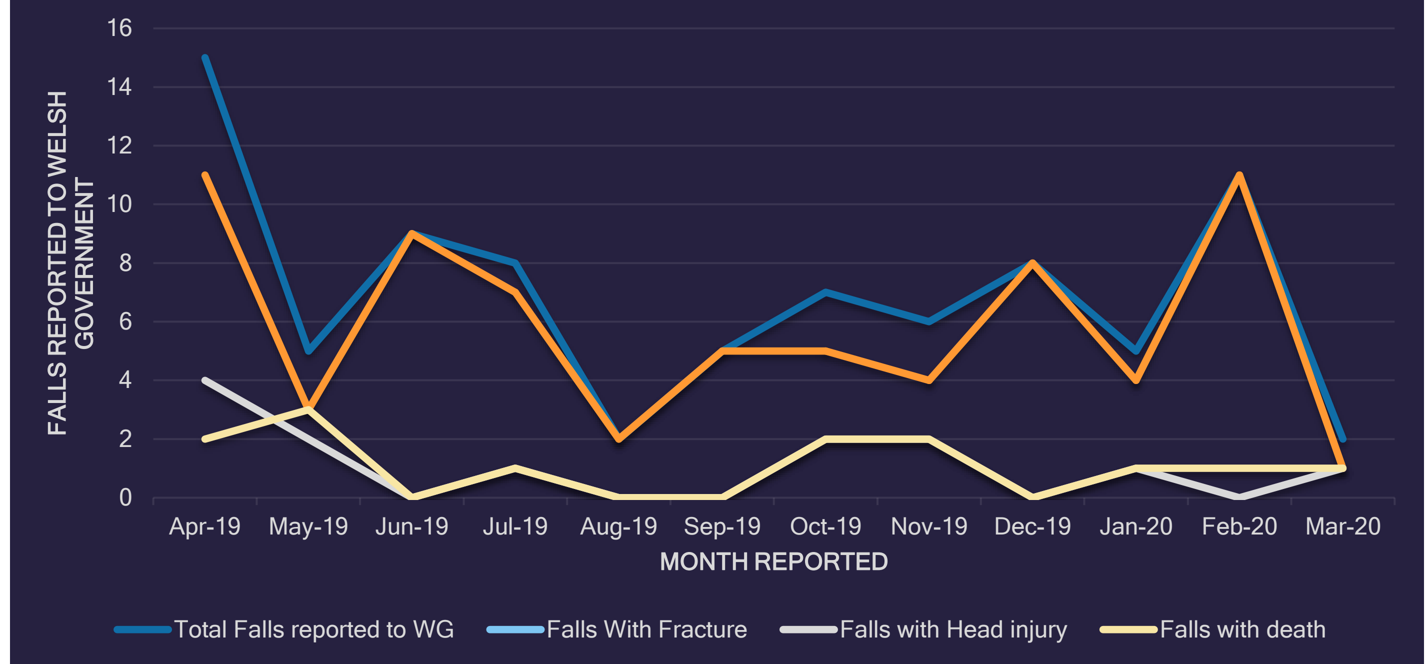
A number of falls result in a fractured bone or a head injury. Inpatient falls which result in a long bone fracture are reported to Welsh Government. An investigation is conducted and presented to the Falls Review Panel. The role of the Falls Review Panel is to review the investigation to ensure that there is learning and themes are identified and overseen by the Falls and Bone Health Steering Group.

Overall, the total number of inpatient falls is reducing, however the severity of harm (at severe and catastrophic levels) has increased in the past two years, specifically for both long bone fractures and head injuries. Whilst this severity of harm represents a very small percentage of all inpatient falls (between 0.3% - 2%), the increase is of concern.

Falls with head injury and death are referred to HM Coroner and an inquest is arranged. There have been occasions where inpatient falls have resulted in other fractures, such as spinal fractures or facial fractures. Whilst not classed as long bone fractures, the SI Team assess these on a case by case basis in terms of the level of harm for the patient and whether these are reportable.

The number of fractures or severe head injury varies from month to month, but shows normal variation.

Graph 8: *Illustrates the total number of inpatient falls reported to Welsh Government between April 2019 and March 2020. It provides detail of those that are fractures, head injuries or when the patient has died within days of the fall.*



In March 2020 due to the Covid-19 global pandemic, Welsh Government issued a national steer that mandated that only falls resulting in unexpected death, were to be reported. This is the reason for the sudden decrease in falls reported for March.

Learning from Serious Incidents

Falls

In response to a number of injurious falls, measures have been put into place in an attempt to reduce avoidable falls:

- Introduction of an ABUHB wide Falls Collaborative, with multidisciplinary membership.
- Recruitment of an Orthogeriatrician for the fractured neck of femur service at Royal Gwent Hospital (RGH), which has driven improvements in the ward based assessments.
- Also at RGH a robust weekend watch list and out of hours handover for continuity of care has been introduced. Along with an anaesthetic pathway to improve post-operative care from recovery to the ward.
- There has also been an extension of the job plan of the hip fracture service Registrars to cover the weekends.
- Launch of an improved Multi-factorial Risk Assessment Tool (MFRA) and incorporation into a booklet with other risk assessments.

- A Learning Event with multidisciplinary staff to discuss lessons learnt.
- Actively minimising the amount of inter-ward transfers for patients at risk.
- Patient falls reduction leaflets provided for patients and families.
- Appropriate use of post-fall assessment document and physiotherapy assessments following falls.
- Adjustment to ward routine i.e. stopping of early morning routine observations at 06:00.
- Improved signage on bathroom doors, to include visuals.

National Early Warning Score (NEWS) / Deteriorating Patient

In response to a number of incidents, e.g. recognition and escalation of the deteriorating patient, the CareFlow Vitals System was further rolled out across the Health Board. This system that monitors and analyses patient's vital signs, providing Clinicians with accurate, real time information for the safest possible patient care. Staff using the system enter patient's vital signs with other clinical observations and assessments at the bedside. It automatically calculates a risk score (using the nationally recognised NEWS score) based on clinical observations, immediately alerting staff of deterioration and advising on appropriate actions.

The introduction of this system highlighted voids in practice, which included inconsistences in undertaking and recording of physiological observations and calculation of the NEWS score. This was identified as having caused delay in escalating deterioration of patients. This resulted in:

- A comprehensive training and education programme rolled out to staff across hospital sites in the use of this system.
- Snap shot observational audits undertaken by Senior Nurses to monitor compliance with the system.
- An additional Senior Nurse was based on site in Ysybty Ystrad Fawr (YYF) to support this workstream.
- A competence based assessment was introduced to monitor the practical skill of recording observations.

Improvement to Theatre Environment and Procedures

Following a number of mis-categorisations of level of harm on the Datix reporting system:

- Training has been undertaken for senior leads in all areas in order to identify how to categorise events into levels of severity, the review and mapping where the checks occur and who carries out the checks. This is supported by an ongoing audit programme by senior leader and peers.
- Anonymised staff surveys have been established for all groups to identify areas of concern, thus encouraging early escalation of concerns observed in a safe environment.

- New Epidural charts introduced to ensure administration of medication via this route are robustly escalated. Training has been provided to theatre recovery staff and ward nurses by the acute pain lead nurse.
- A significant effort has been undertaken to promote 'Stop Before You Block' and this practice is now embedded within the organisation and signage displayed in all anaesthetic areas.
- WHO checklist audits, have been conducted.

Plaster Cast Care in Trauma and Orthopaedics

- Development of a neurovascular assessment tool for Trauma and Orthopaedic (T&O) patients to reduce risk of pressure ulcer development associated with cast application.
- Specialist plaster technicians are now available for trauma lists to apply plasters.
- Information on the management of plasters and requirement to investigate joint pain within plasters has been added to the educational induction programme for T&O doctors and nursing staff.

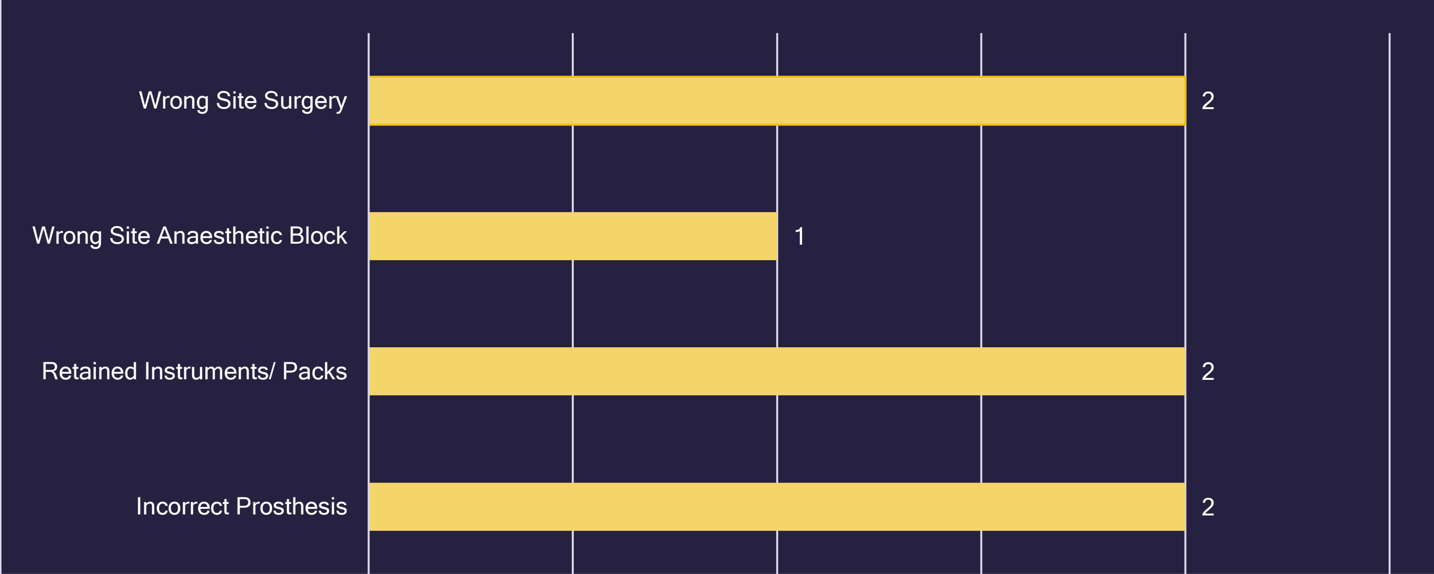
Learning from Mental Health and Learning Disabilities Division

- Findings of SI reviews have instigated the review and amendment of the Clozapine Policy – specifically in relation to the management of constipation.
- Following an incident the Therapeutic Observations and Engagement policy was updated, to include the requirement to assess a person's mental state when they are being given Section 17 leave from a Mental Health Ward, prior to the leave being granted.
- Due to the lack of a multidisciplinary team when assessing people who are in crisis, the current crisis team being uni-disciplinary (nursing), and having a multi-disciplinary team may give a different perspective on an assessment. There was development of the clinical model for acute care in mental health services, specifically the liaison model and multi-disciplinary aspect of the Crisis Resolution Home Treatment Teams.

Serious Incidents – Never Events

There were 7 Never Events occurring during 2019-20 including: wrong site surgery, wrong site anaesthetic block, retained instruments/packs and incorrect prosthesis.

Graph 9: *details of the 7 Never Events 2019-2020*



There were no real themes identified however a broad number of actions and associated learning has been undertaken to minimise recurrence. This includes an overarching Action Plan to address incidents in theatres, with improvements including;

- A monthly Safety Group meeting has been established to strengthen the governance framework.
- Processes to ensure cross divisional learning across specialities and sites were commenced – including dissemination of learning at Theatre Teams Audit days and via monthly team meetings.
- Theatre Collaborative utilised to support information sharing and improving good practice.
- Datix training for staff.
- Senior review and sign off of Datix.
- Mechanisms to feedback investigation outcomes to promote learning across all theatres.
- Incidents reviewed to monitor trends and target improvements.
- Ongoing audit programme established – with LoccSips audits undertaken in General, Gynaecology, Ophthalmology, Urology and ENT Theatres.

Learning from Never Events

In 2019/20 an internal audit of the completeness and effectiveness of the WHO Surgical Safety Checklist was undertaken. This provided reasonable assurance. The following actions were implemented to address findings in the report and subsequent learning:

- The WHO safety checklist template was adapted for application in Ophthalmology laser therapy treatments following a Never Event wrong site procedure and Never Event retention of throat pack. This checklist was formatted with relevance to other minor and invasive ophthalmic procedures.
- The Ophthalmology checklist is now completed for all patients undergoing ophthalmic surgical procedures using laser therapy. Compliance has been confirmed by live auditing for a period of one month and an audit programme is now in place to monitor compliance going forward.

- Learning and progress is effectively communicated at induction of new staff, via LocSSIP training and departmental meetings with all staff disciplines.
- The maternity pathway has been revised to include an improved version of the safety checklist to reflect the WHO template, ensuing consistence across specialities.
- A recent observation revealed inconsistencies in the interpretation of the 'sign in' section of the WHO checklist. This, in part, is due to the design and use of a Treatment room within the theatre suites in two locations. An improvement initiative to revisit the WHO checklist process is underway to confirm that practitioners of all disciplines undertake the process consistently, accurately, efficiently and in compliance with NatSIPP guidance.
- The surgeon, scrub practitioner and circulating practitioner now verbally confirm the size and type of prosthesis to be implanted, to prevent errors.

A significant effort has been undertaken to promote 'Stop Before You Block' and this practice is now embedded within the organisation and signage displayed in all anaesthetic areas.

Redress

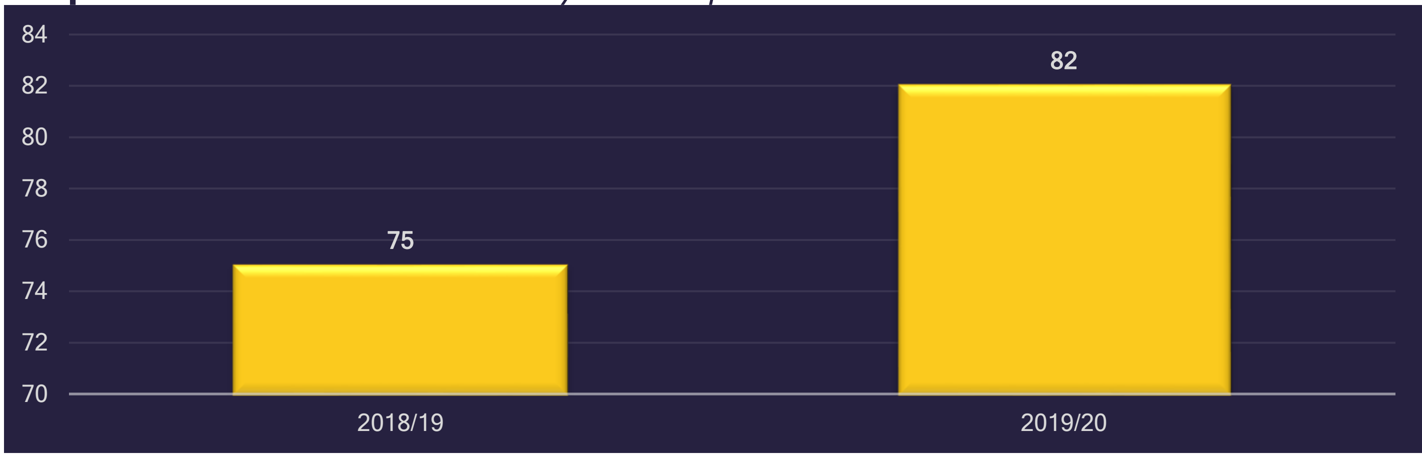
Under the framework for investigating concerns including those of patient safety incidents, there is an obligation on Health Boards where harm has occurred or is alleged to have occurred, to consider whether there is a qualifying liability in tort i.e. are there failings in care which amount to a breach of duty of care and that breach of duty led to the harm experienced or materially contributed to it. The test of a breach of duty is the same as the legal test and 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".

The Redress Panel

The Health Board has established a Redress Panel to make determinations in those cases where it feels there have been failings and the failings may have led to harm. Redress Panel now has a permanent chair, Assistant Medical Director (Public Health) and members include representatives of the Medical Director, Nurse Director, Director for Therapies and Health Science, Finance Director and Board Secretary. Cases are heard every three weeks. In addition to making determinations of a qualifying liability there is an increased focus by the Panel to ensuring adequate learning has taken place and whether further learning is required on a corporate/division wide basis and in some instances on a national basis.

The final Panel for 2019/2020 was suspended due to the Covid-19 pandemic. The Panel heard 82 cases during the year an increase of 7 (9%) from the previous year as illustrated on Graph 10.

Graph 10: *Redress Cases heard by Panel April 2018 to March 2020*

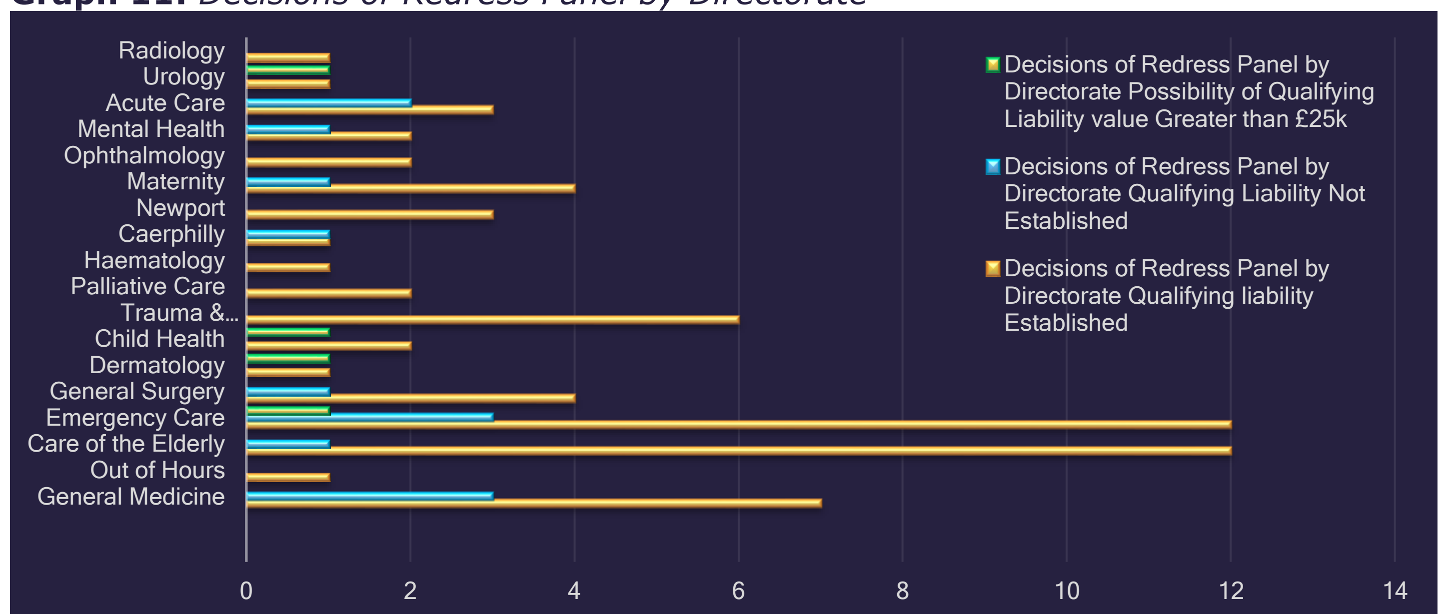


Decisions of Panel

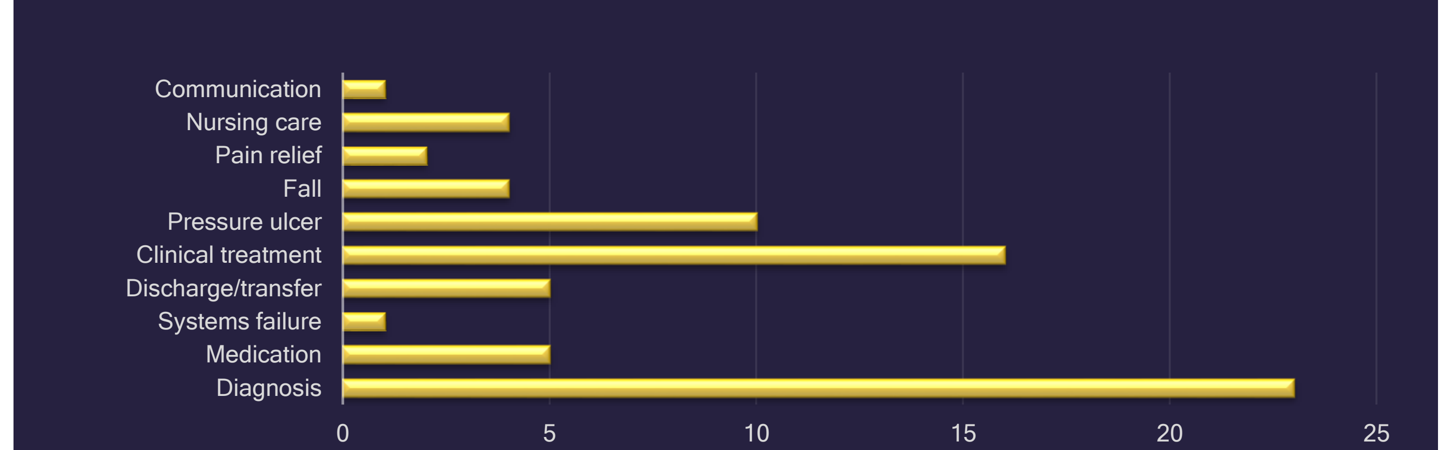
Qualifying Liability Established	65
Qualifying liability not established	13
Cases where potential of Q/L but taken out on value	4
Total number of cases heard in Panel	**82**

Cases considered by Panel do not only consider those concerns raised by patients or their representatives but also consider concerns raised by staff, either as a patient safety incident or via Safeguarding. Of these cases, 15 arose by way of patient safety incidents and 17 involved a complaint and a patient safety incident.

Graph 11: *Decisions of Redress Panel by Directorate*



Graph 12: *Themes in cases where qualifying liability established*



The main theme in cases whereby qualifying liability was established is associated with diagnosis. Lessons learnt from issues connected with the theme of diagnosis can be wide and varying as the issue can range from a failure to appreciate the subtly of a fracture via x-ray to a failure to appreciate the significance of a presenting symptom(s) to reporting errors on radiological investigations. Often the case will be anonymised and used in teaching sessions within the relevant clinical areas and the individuals concerned will be asked to reflect on the case and use this to inform their clinical practice. In other cases there may be changes to systems and processes in the care to be provided e.g. agreement between paediatric ward managers of a standard to include recording of blood pressure twice daily and completion of a full set of observations on admission to Children's Assessment Unit or ward area. In addition re-attendance guidelines have been developed and embedded across the paediatric directorate.

Lessons Learned from Redress

Two cases involving the out of hours radiology reporting system highlighted concerns with governance and indemnification. This was escalated through Redress Panel and reported to the All Wales Meeting of Directors of Therapies and Health Sciences. Consequently a meeting has been held with the out of hours reporting service and a new system of governance has been agreed with the Health Board. As a result of the concerns raised by the Health Board an All Wales investigation was undertaken.

The concerns and lack of assurance was such in two particular cases presented that they have led to the development of Learning Events. These are multi-disciplinary meetings involving not only members of the teams providing the care but also cross divisional and cross specialty personnel. The meeting discusses the care provided to the patient and the action that has been taken and needs to be taken within the ward, directorate, and division across the Health Board. As a consequence of their success they are now to be repeated on a more regular basis especially for those cases which are complex and raise multiple clinical and nursing failures.

A number of cases involving falls resulting in a fracture of a long bone have led to the Inpatient Falls Policy and the multi factorial risk assessment accompanying this to be reviewed. This in turn has led to the development of a falls learning collaborative with the assistance of ABCi in a similar vein to the pressure ulcer collaborative. The pressure ulcer collaborative has been very successful in reducing the number of inpatient acquired pressure ulcers.

Public Service Ombudsman for Wales (PSOW)

The number of complaints that are referred to the PSOW provide a marker of the quality of the Health Board's investigation and its initial responses to the complaints received.

Quarterly meetings with the PSOW Improvement Officer to discuss handling and liaison issues, alongside regular telephone contact with the Investigation Officers, have been positive. This year no concerns have been raised with regard to the Health Board's response to the PSOW when dealing with complaints that have been referred to them.

During 2019/20 good working relationships have been maintained and efficient processes are in place to ensure deadlines are met. Where delays are encountered, and the PSOW's deadline cannot be met, an escalation process has been put in place with the Executive Team.

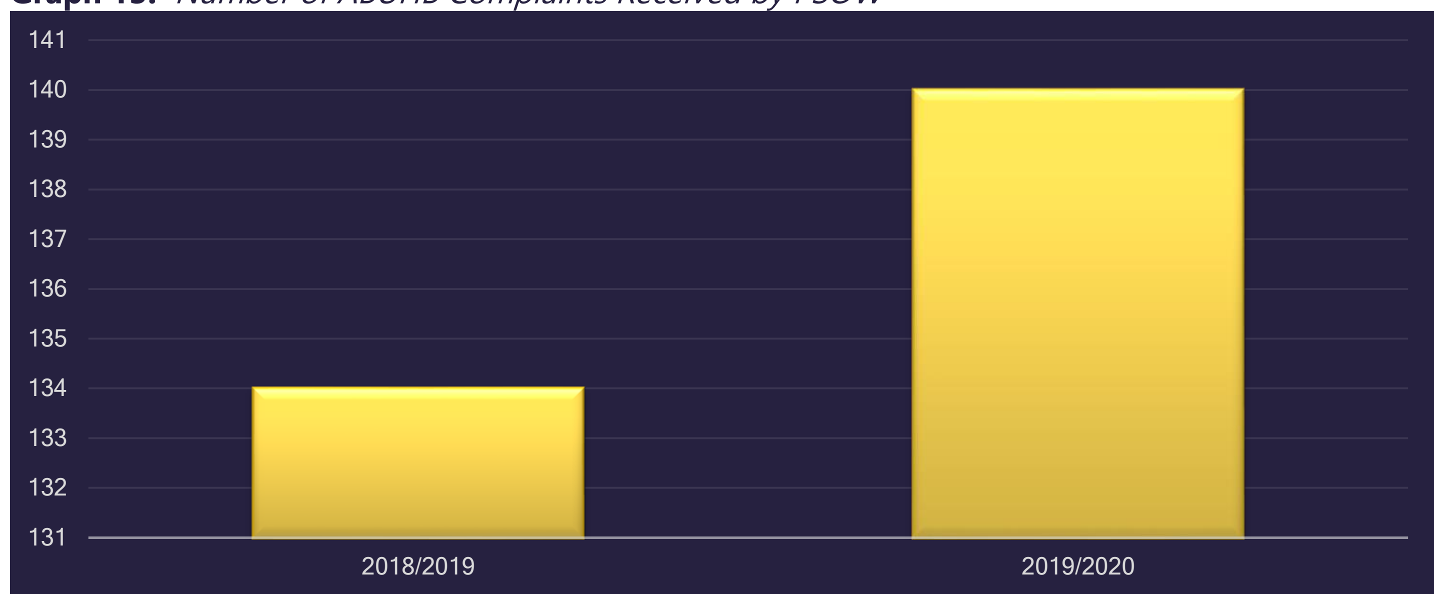
This year, the way in which PSOW cases are recorded by the Health Board has been improved through a more effective use of Datix. This enables information relating to the whole complaint, from first receipt by the Health Board to the final involvement of the PSOW, to be recorded on one electronic file.

Number of complaints received by PSOW

During 2019/2020 the PSOW received 140 complaints related to ABUHB. This represents an increase compared to 2018/19 of 4.5%.

The following chart shows the number of complaints received by the PSOW over the last three years, showing a year-on-year increase. The higher number of PSOW complaints received in 2019/20 reflects the increase in the number of overall complaints received by the Health Board during 2019/20.

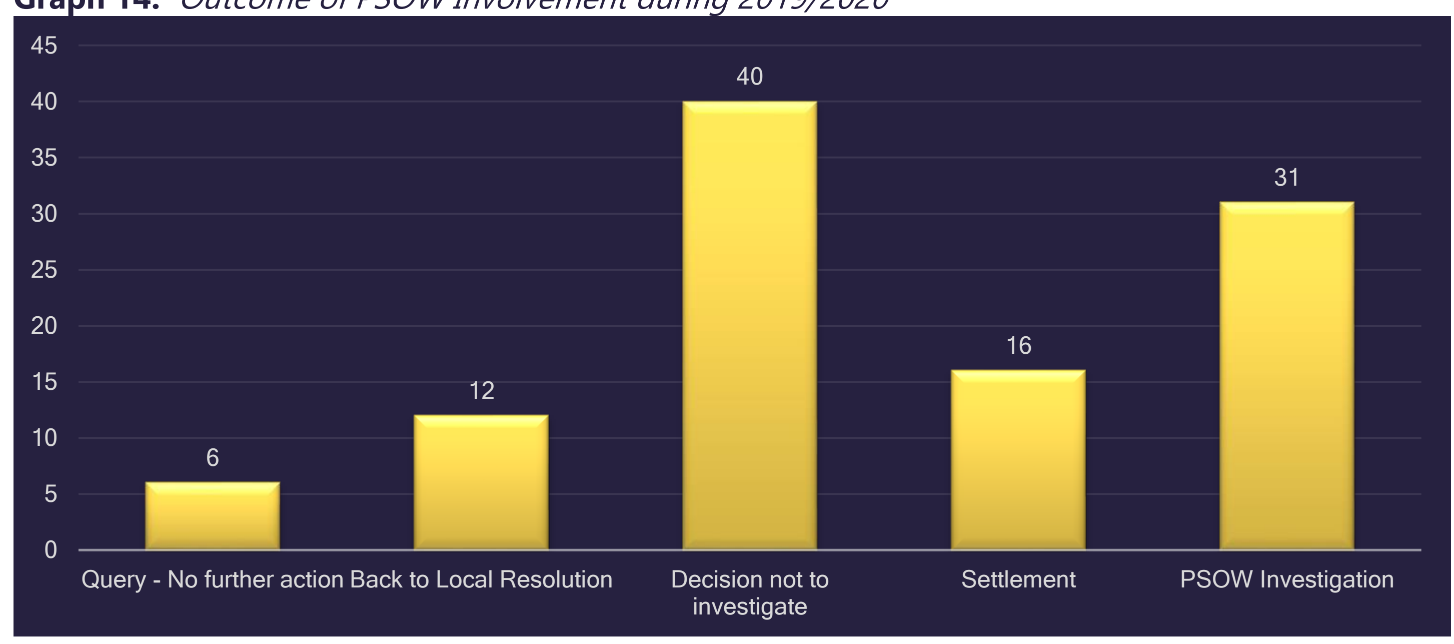
Graph 13: *Number of ABUHB Complaints Received by PSOW*



A proportion of the complaints shown in the graph would have been rejected at the outset by the PSOW and would have remained anonymous to the Health Board, meaning that numbers received by the PSOW differs from the number that require further Health Board input.

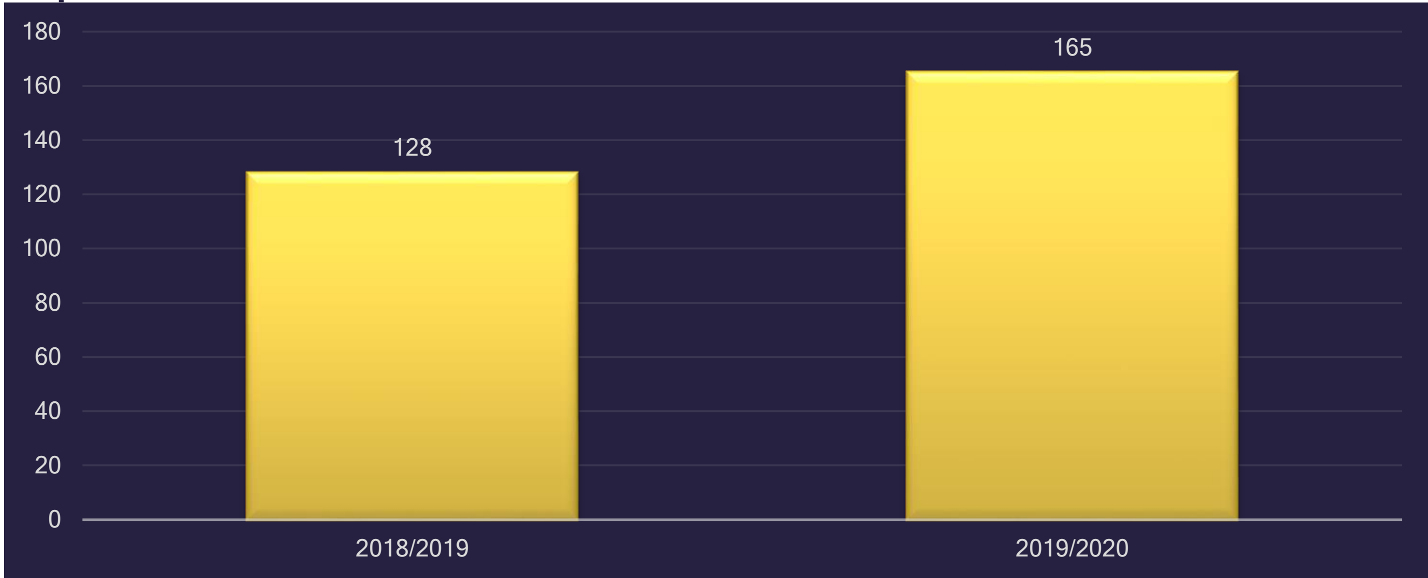
105 PSOW complaints were referred back to the Health Board for further involvement, including 39 from 2019/20 and 66 related to complaints dealt with by the Health Board in previous financial years. The outcome of PSOW cases received in 2019/2020 is shown in graph 14:

Graph 14: *Outcome of PSOW Involvement during 2019/2020*



As shown in graph 14 out of the 105 complaints dealt with, 31 required a full PSOW investigation.

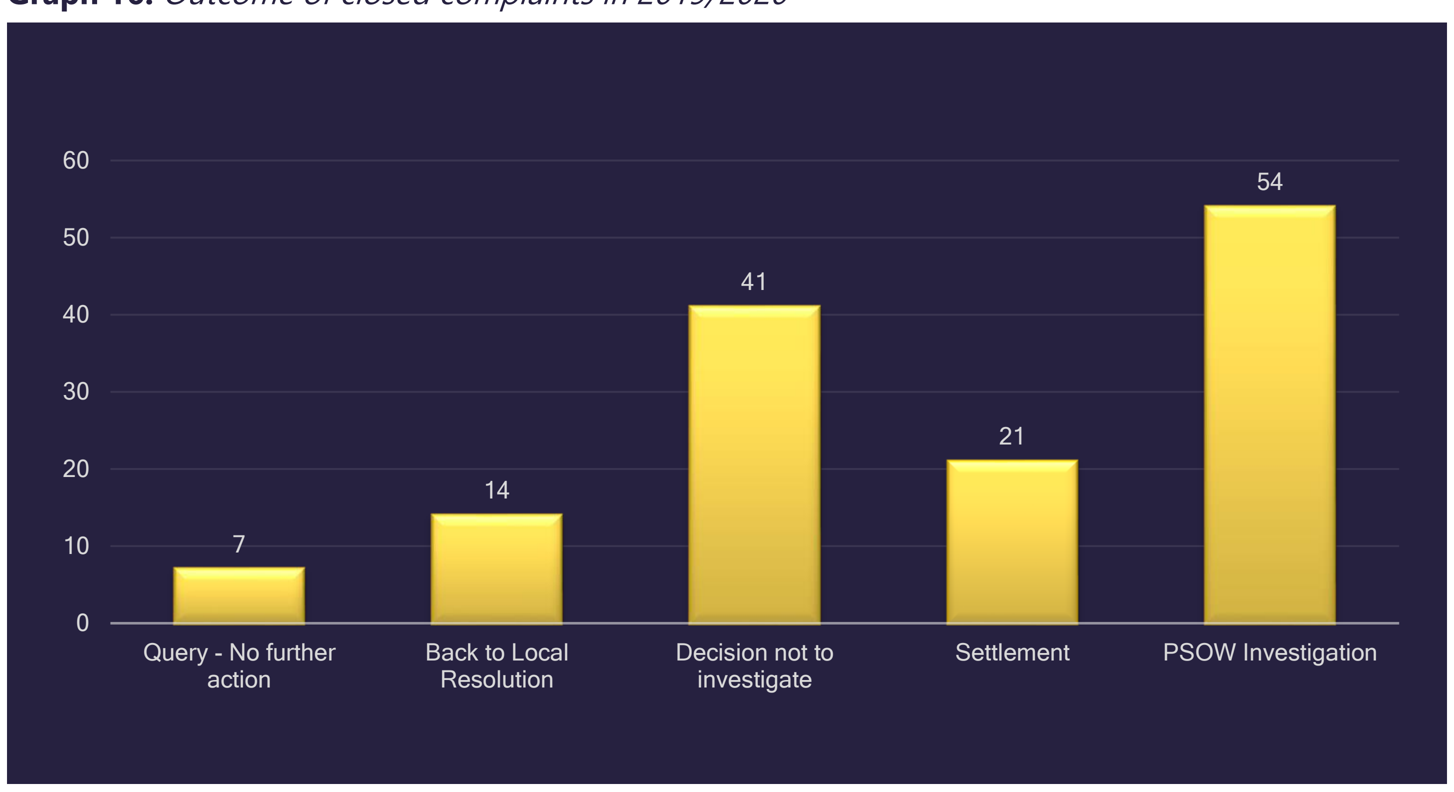
Graph 15: *Closed PSOW Cases*



Outcome of PSOW complaints closed during 2019/20

Although the PSOW closed 165 cases in 2019/20, the Health Board itself closed 137 PSOW cases. The difference of 29 can be attributed to anonymous complaints made that the Health Board does not have knowledge of. The 137 cases includes complaints received by the Health Board in previous financial years, not just complaints 2019/20.

Graph 16: *Outcome of closed complaints in 2019/2020*

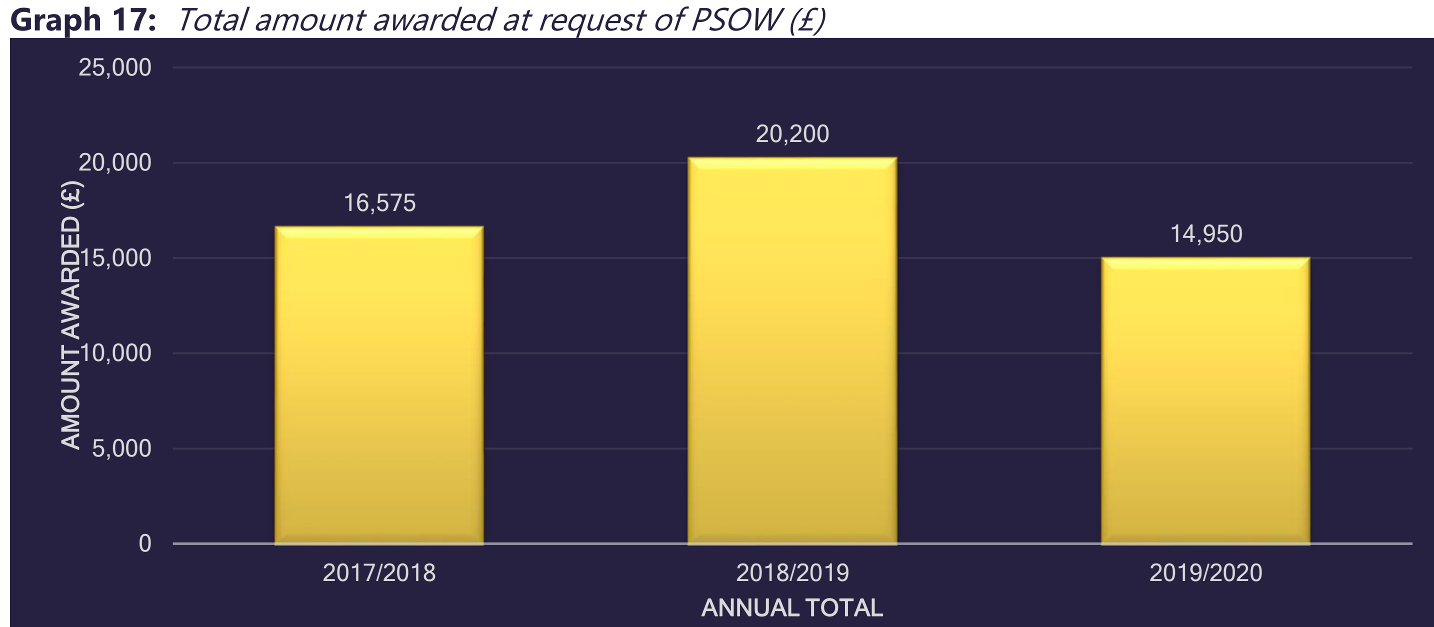


As shown in graph 16, out of the 137 closed cases, 54 were relating to PSOW investigations. 37 of these were upheld and 17 were not upheld. This represents a 68.5% figure of upheld complaints. This is compared to 73.8% of complaints upheld in 2018/19.

PSOW Financial Settlements

Where the PSOW considers there has been an injustice they are able to recommend a financial payment. This can be at any stage, i.e. as a settlement or as part of the recommendations following a full investigation. The following information shows the financial amount paid out by the Health Board at the request of the PSOW over the last three years, indicating a reduction in payments in the last financial year.

Graph 17: *Total amount awarded at request of PSOW (£)*



Learning from PSOW Cases

Medication for Patients with Parkinson's Disease

Inappropriate prescription and single dose of haloperidol, contraindicated in patients with Parkinson's disease, led to learning and inclusion of the management of Parkinson's disease being introduced into the F1 teaching programme at Nevill Hall Hospital for 2019/20. In addition, the Symptomatic Management of Parkinson's Disease was also added to the Health Board's Training App.

Management of Pressure Ulcers

Lack of timely action in relation to a pressure ulcer within the Medical Assessment Unit led to an avoidable pressure ulcer. Since this patient was admitted to the Medical Assessment Unit, improvements in pressure area management have been put in place, which include:

- Comprehensive assessments are undertaken on admission to hospital. Any reason for not undertaking assessments is documented fully.
- Appropriate care is provided regardless of patient location.
- There is an embedded focus on patient safety at all the hospital bed management meetings.
- The ward is a member of the Pressure Ulcer Collaborative. This is a programme of work launched in September 2018 developed by the Health Board. The MAU team have been at the forefront of the collaborative.
- There is a Tissue Viability Nurse Champion in place.

Compliments

Compliments are useful for measuring and tracking feedback. They can show improvements in performance, and provide a baseline for measuring patient satisfaction, generating meaningful data can help drive continuous improvement. Compliments acknowledge, reward and promote desirable behaviours and practices, also providing staff with social recognition. Positive feedback is pivotal for morale and wellbeing, and reinforces what the Health Board, is striving to provide.

Historically, compliments have not been captured within ABUHB, however during 2019-20, better systems and processes have been instigated to ensure that this important feedback does not go unrecognised. Compliments are received within a variety of formats, including letters, emails, telephone calls and conversations.

Some examples are included as follows:

"Thank you for running such a great department. And thank you to all the staff who saw me with a smile."

A&E, Unscheduled Care
April 2019

"To all the staff thank you for your care".

Mental Health Team
June 2019

"I would like to thank the doctors and staff for an unbelievable experience with fantastic support and assistance with this minor procedure."

Dermatology, Scheduled Care
August 2019

"You are all superb and I thank you most sincerely".

Chepstow Hospital
Primary Care & Community
October 2019

"I wanted to let you know the tremendous difference you have made to the patient's quality of life and the gratitude had by both the patient and her daughter."

Mental Health
September 2019

"The level of care from all the Team was outstanding and we would like our grateful thanks noted and passed onto the staff."

GP Out of Hours, Primary Care & Community
May 2019

"I was in, seen, x-rayed, given advice and a splint, and discharged, all within half an hour! Can't thank the staff enough."

A&E, Unscheduled Care
November 2019

2019/20 – Learning through themes

A learning organisation is one where patient safety, quality of care and a positive experience is core. Key themes for learning include the necessity to;

Share and disseminate lessons learnt

- Development of the overall approach to learning from incidents and complaints and sharing of lessons learned and actions implemented.

- Further development of the Learning Framework and emphasis on learning and continuous improvement is required in order to foster a learning organisation that thrives through its responses to incidents and complaints, is flexible, adaptive and productive and future-focused.

Ensure a robust and comprehensive training programme

- There is a significant need for the delivery of Investigating Officer and Complaints response training in order to improve the quality of responses and organisational learning.

Continually strive to improve complaints handling

- Rapid review meetings to assign most relevant division to lead will streamline initiation of processes and define roles and responsibilities more clearly.

Ensure timeliness of investigations and quality responses

- Use of virtual meetings will enable greater flexibility in managing calendars of many senior clinicians and nursing staff, leading to timely meeting scheduling.

Streamline the serious incident investigation process and response times

- Action Plans were not being submitted alongside the investigation report and were required in order to close the incident with WG. PTR would experience many delays in receiving action plans back. In order to address this Action plans are populated throughout the SI process as discussed within the meetings. This is starting to yield improved results.

Minimise the risk of the occurrence of Never Events

- More robust systems and processes in place to address issues.

Improvement actions for 2020/21

- A suite of training modules to be delivered by the PTR team engaging stakeholder partners, focusing upon Complaints and Serious incident investigation.
- Further enhanced relationships with PSOW and officers.
- Newsletter to be introduced in order to share and promote good practice.
- Continued improvement in compliance to turnaround times for complaints and incidents, with Divisional trajectories set.
- Complaints Coordinator Forum to be established as a support network.
- More robust trend analysis of complaints/incidents to inform areas for learning and development.
- The improved use of Datix will facilitate analysis and reporting of complaints information in future. This will ensure alignment with the work that is being progressed by the 'Once for Wales Concerns Management System Programme (OfWCMS), developing a consistent approach in the use of Datix across all Health Boards. OfWCMS is a new approach to how NHS Health Boards and Trusts in Wales will report, record, monitor, track, learn and make improvements from incidents, complaints, claims, adverse outcomes, risks and events that happen in healthcare.
- Further focus on the development of learning, with evidence of improvement.