GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 4.3** **30 May 2019**

University Health Board Report
CONCERNS (COMPLAINTS, CLAIMS AND PATIENT SAFETY INCIDENTS) – UPDATE ON HIGH-RISK EVENTS

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Purpose of the Health Board Report
This report provides the Board with a summary of high-risk concerns since the last report to Board on 28 March 2019. The report provides information in relation to complaints performance and the improvements that have been implemented since November 2018. In addition, the report outlines serious incidents reported to Welsh Government (WG) and Regulation 28 reports received from Her Majesty's Coroner. The report also highlights the current position in relation to the review of patient safety incidents and compliance with Patient Safety Solutions.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within 'Cwm Taf Cares' 3 Year Integrated Medium Term Plan 2019 - 2022 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) quadruple aim are being progressed. • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future. • To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board.
Supporting evidence	N/A
Engagement – Who has been involved in this work?	
The information within the report has been provided by the corporate concerns team, from records held on the Datix risk management system.	

Health Board Resolution to:							
APPROVE		**ENDORSE**		**DISCUSS**		**NOTE**	√
Recommendation	The Health Board is asked to: • **NOTE** the report						
Summarise the Impact of the Health Board Report							
Equality and diversity	Concerns are managed within the framework of Putting Things Right, ensuring that all issues are dealt with equitably. There are no specific implications relating to equity and diversity within this report.						
Legal implications	Concerns are managed in accordance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011						
Population Health	There are no population health implications of this report.						
Quality, Safety & Patient Experience	The individual cases summarised within this report reflect issues relating to quality of care, patient safety, and patient experience.						
Resources	There are nor resource implications related to this paper, with the exception of the costs related to redress and clinical negligence claims associated with the issues alluded to within the paper.						
Risks and Assurance	The cases summarised within this report reflect financial, clinical and reputational risk. The Health Board has systems and processes in place to manage and mitigate these risks. Systems and process are in place to support the investigation of concerns and identification of lessons learned to minimise the risk of recurrence, and where appropriate, changes are made to systems and processes.						
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The work reported relates specifically to Standard 3.1 Safe and Clinically Effective Care, and Standard 6.3 Listening & Learning from Feedback.						
Workforce	There are no workforce implications associated with this report.						
Freedom of Information Status	Open						

CONCERNS (COMPLAINTS, AND PATIENT SAFETY INCIDENTS)
UPDATE ON HIGH-RISK EVENTS

1. SITUATION / PURPOSE OF REPORT

The report provides the Board with a summary of high-risk concerns currently being managed within the Health Board. The report includes information in relation to the management of complaints, performance against the 30 working day target, and the improvements that have been implemented to improve compliance.

In addition, the report outlines serious incidents reported to Welsh Government between 1 March 2019 and 30 April 2019, and Regulation 28 reports received from Her Majesty's Coroner since the last report to Board. The report also highlights the current position in relation to the review of patient safety incidents and non-compliance with Patient Safety Solutions.

2. BACKGROUND / INTRODUCTION

Concerns are managed in accordance with All Wales *Putting Things Right* Guidance. The Health Board's assurance processes require that concerns are reported and scrutinised at clinical business and governance meetings, Quality, Safety and Risk Committee and via quarterly trend reports and the Concerns Scrutiny Panel.

Putting Things Right requires organisations to thoroughly investigate concerns in a timely manner. This includes engagement with patients or their families and the identification of learning leading to improvements in care and services. During 2018 there were delays in the conclusion of investigations resulting in decreased compliance with the targets outlined in Putting Things Right, specifically the 30 working day target for responding to complaints and timely reporting and investigation of incidents.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

3.1 Formal Complaints

It should be noted that although complaints often relate to several issues, only the primary reason for the complaint is recorded. A large proportion of formal complaints relate to three main categories– a breakdown for those received between 1 March and 30 April 2019 are reflected in the chart below:

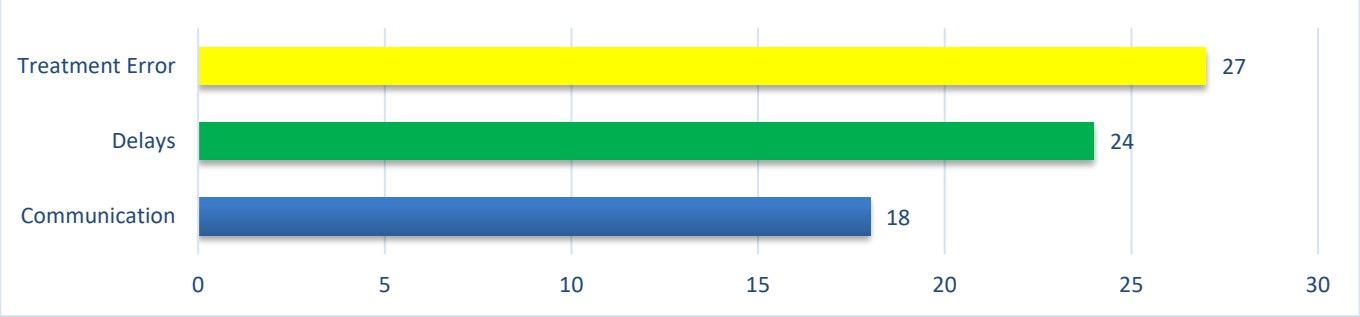

Chart 1: Types of complaints received – top 3 received

It is worth noting that the categories are recorded based on the patient experience when the complaint is received and not on the outcome following investigation.

At the end of Quarter 4, there were 141 formal Complaints which were 'ongoing' i.e. in the process of being managed, 47 of these relate to Princess of Wales and 95 are related to concerns generated within the former Cwm Taf University Health Board. There are 8 historic complaints open which were received over 6 months ago. These are complex and are still under investigation. Compliance with complaint response times during Quarter 4 has increased to 29%, this is due to continued targeted improvement work undertaken by the team.

The current trend for compliance with complaints response times within 30 working days is reflected in the table below:

Area	Number			
	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Total number of formal complaints being managed	98	108	100	141
Total Number closed	89	73	75	110
Compliance with 30 working day target	17%	18%	23%	29%

Table 1: Complaints Information

Of the number of complaints closed in Quarter 4, the response times are further categorised below:

Number of Complaints open	**141**	
Number of Complaints overdue	**45**	Over 30 working days **- 37**
		Over 6 months - **8**

Table 2: Current Position for Complaints Response Times (20.05.19)

In terms of wider performance in Quarter 4, the summaries below identify high-risk concerns and are highlighted in the following categories:

3.2 Patient Safety Incidents

3.2.1 Serious Patient Safety Incidents

The position in relation to serious incidents from the 1 April 2018 to the 31 March 2019 is summarised in the following table:

Time period	Quarterly trend			
	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
New Serious incidents reported	91	120	109	58
Never events included in above reports	0	1	0	0

Table 3: Serious Incidents Reported to WG

The figures in the table above reflect the trend by quarter, of note, quarter 2 broadly reflects reporting that took place related to retrospective reporting of serious incidents within maternity services and quarter 4 reflects the refinement of reporting pressure damage which no longer requires the reporting of unavoidable damage, hence lowering the incidence.

A total of 43 serious incidents were reported to Welsh Government between the 1 March 2019 and 30 April 2019, this is the number of incidents that have been submitted since the last report to Board and is therefore not reported by Quarter. The overview of the category of the number of incidents by service area from the 1 March 2019 to 30 April 2019 is reflected in the table below, which, for the first time contains information relating to Princess of Wales (to note, at present the latter is presented as site based rather than service based and therefore not comparable in terms of directorate or service specific):

	Slip, Trip or Fall	Absconding	Admission / Transfer / Discharge	Delays	Equipment	Health Records / Documentation	Infection	Maternal Event	Patient injury	Radiological Investigations	Self Harm	Unexpected or Trauma Related Death	Total
Acute Medicine and A&E	11	0	1	1	0	0	1	0	0	0	0	1	15
Anaesthetics, Critical Care & Theatres	0	0	0	0	0	1	0	0	0	0	0	0	1
Children & Young People	0	0	1	0	0	0	0	0	0	0	0	0	1
Facilities	0	0	0	0	0	0	1	0	0	0	0	0	1
Head and Neck, Eyes, ENT, Oral and Maxillofacial	0	0	0	4	0	0	0	0	0	0	0	0	4
Mental Health	1	2	1	0	0	0	0	0	0	0	1	1	6
Merthyr Tydfil & Cynon Locality	1	0	0	0	0	0	0	0	1	0	0	0	2
Obstetrics and Gynaecology including Sexual Health	0	0	1	0	0	0	0	1	0	0	0	0	2
Pathology	0	0	1	0	1	0	0	0	0	0	0	0	2
Princess of Wales – Medicine	0	0	0	0	0	0	1	0	0	0	0	0	1
Princess of Wales - Surgical	2	0	0	0	0	0	0	0	0	0	0	0	2
Radiology	0	0	0	1	0	0	0	0	0	1	0	0	2
Rhondda & Taf Locality	4	0	0	0	0	0	0	0	0	0	0	0	4
Total	19	2	5	6	1	1	3	1	1	1	1	2	43

Table 4: Directorate & Category of incidents Reported between 1 March to 30 April 2019

3.2.2 Review of Patient Safety Incidents

Within the Health Board the process for the management of incidents states that all incidents should be reviewed within 2 working days, investigations undertaken within 7 working days for no/low harm incidents and 60 working days for moderate/severe/death incidents.

As at the 21 May 2019, the Health Board has 2,065 incidents either currently awaiting review (607) or investigation in progress (1,458). Of these 81% (1,698) are initially reported as no or low harm. The number of incidents currently being investigated is partly reflective of the increase in the number of incidents reported following transition of Bridgend services on the 1 April 2019. Accounting for this increase, the number of incidents that are currently open remains above an acceptable standard.

Work continues to support clinical areas with the review and investigation of incidents, including working alongside individuals and teams with responsibility for managing incidents, highlighting areas of concern and risk, through scheduled provision of quarterly reports to inform clinical business and governance meetings, generation of ad hoc reports wherever requested and escalation to the weekly Patient Safety Executive Catch up. Targeted support continues via the Patient Safety Improvement Managers to ensure investigation is undertaken in a timely manner, supported by an organisation wide training programme. A breakdown by Directorate and current status is provided in the chart below:

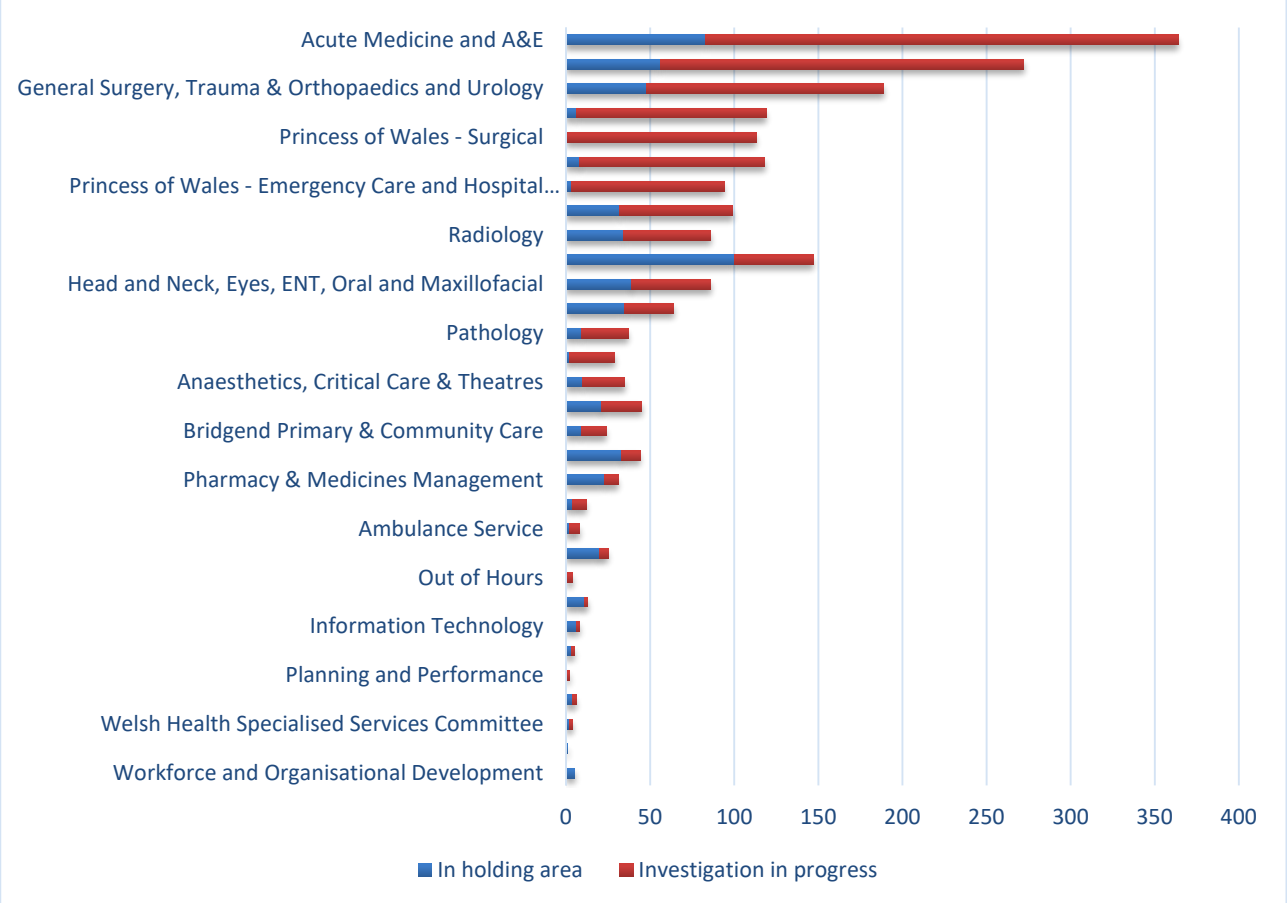

Chart 2: Incidents Current Status by Directorate

3.3 Inquests:

There have been two inquests that have resulted in the generation of a Regulation 28 Report since the last report to Board as detailed below:

> An inquest relating to a baby born at home, concluded that it was too premature to survive. The evidence presented highlighted that further blood tests were not undertaken to check for infection markers, the mother's care was not escalated to a Consultant when she had presented in hospital with pain in the hours before the birth and a decision to admit under observation should have been made. The matters of concern raised by Her Majesty's Coroner relate to the lack of account from the treating medical registrar which impacted on the quality of the investigation.
>
> An inquest that was held in respect of a baby, concluded had died of cardio pulmonary failure, resulting from a failure to deliver in good time. The areas of concern raised by the Her Majesty's Coroner relate to unclear clinical leadership, insufficient staffing levels, high acuity and no clear line of responsibility for escalation. In addition, the report identified that there was poor standard of CTG interpretation and record keeping, specifically MEWS charts and the partogram was not completed.

The concerns echo findings within the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives Report following their recent review of Maternity Services within the Health Board. The actions required to address these issues form part of the overarching maternity services improvement plan. The Regulation 28 Reports have been shared with the Directorate, Welsh Government and will also be shared with the Concerns (Claims, Redress & Serious Incidents) Scrutiny Panel and the Quality Safety and Risk Committee.

3.4 Patient Safety Solutions

Patient Safety Solutions are issued in two formats:

- **ALERTS**: this requires prompt action with a specified implementation date to address high risk/significant safety problems.
- **NOTICE**: This is issued to ensure that organisations and all relevant healthcare staff are made aware of the potential patient safety issues at the earliest opportunity. A Notice allows organisations to assess the potential for similar patient safety risks in their own areas, and take immediate action.

The Health Board is currently non-compliant with 1 alert and 2 notices. A summary of these is provided in the table in **Appendix 1**, along with the actions in place to reach compliance and a revised timescale.

4. RECOMMENDATION

The Health Board is requested to:

- **NOTE** the report.

Freedom of Information Status	Open.

Appendix 1 – Patient Safety Solutions Non-Compliant & Outside of Timescale

No. Patient Safety Alerts & Notices Name & ID	Issued	Progress update & Outstanding Actions	Executive Lead	Deadline for completion & RAG status
PSA008 Nasogastric tube misplacement: continuing risk of death and severe harm	22.05.17	CE strips non marked being used (WG agreement) so HB remains non-compliant. Further work is being undertaken by the suppliers of the PH strips to either CE mark the product, alternatively another supplier will need sourcing for supplying Wales or possible changes to PH testing practice will be required.	Medical Director	30.10.17 In progress No Anticipated date of compliance as waiting for All Wales solution.
PSN030 The safe storage of medicines: cupboards	04.04.16	WG have provided all Health Boards with a self-assessment tool to complete. CTUHB have completed self-assessment tool and awaiting approval. Areas of non-compliance have been identified and actions taken to minimise the risk.	Director of Primary, Community and Mental Health	26.08.16 In progress No anticipated date of compliance available due to the requirement of modernisation of all medicines storage across the HB
PSN046 Resources to support safer bowel care for patients at risk of autonomic dysreflexia.	23.10.18	The notice has been disseminated to all Clinical Areas. There is currently a Protocol in place which refers to Patients with spinal cord injuries. Processes are in place and training programmes delivered across the Health Board - Acute & Community Care. The Guideline is being reviewed and a Standard Operating Procedure is being developed which will included more detailed information highlighted in the notice. The Guideline and the Standard Operating Procedure needs to be approved before compliance can be confirmed.	Medical Director	29.03.19 In progress Anticipated date of compliance 30.06.19