



University Health Board Report

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

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Purpose of the University Health Board Report

This report provides the Board with a summary of high-risk concerns since the last report to Board on 30 May 2019. The report provides information in relation to complaints performance and ongoing improvement work. 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 non-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, these in summary are;

- 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.

This report focuses mainly on improving quality, safety and patient experience.

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: <ul style="list-style-type: none"> • 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		The resource implications relate to penalties and redress payments.					
Risks and Assurance		The cases summarised within this report reflect financial, clinical and reputational risks. The Health Board has robust 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, CLAIMS, 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, including performance against the 30 working day target up June 2019, and the improvements that have been implemented to improve compliance.

In addition, the report outlines serious incidents reported to Welsh Government between 1 April 2019 and 30 June 2019, new Regulation 28 reports received from Her Majesty's Coroner since the last report to Board on 28 March 2019.

The report 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 including at clinical business and governance meetings, Quality, Safety and Risk Committee 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.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

3.1 Formal Complaints

3.1.1 Complaints Themes and Trends

The number of complaints received has been relatively constant, however, in April 2019, changes were made to the reporting of formal and informal complaints data. Prior to April 2019, Health Boards across Wales were coding complaints data differently within their Datix risk reporting systems. Formal guidance has since been issued by Welsh Risk Pool to all Chief Executives and Directors of Nursing setting out the requirements, timescales and definitions for the new complaints submission proforma. From 1 April 2019, any concerns which cannot be managed within 2 working days are now logged as a formal complaint. This change together with the boundary change has increased the number of formal complaints being reported.

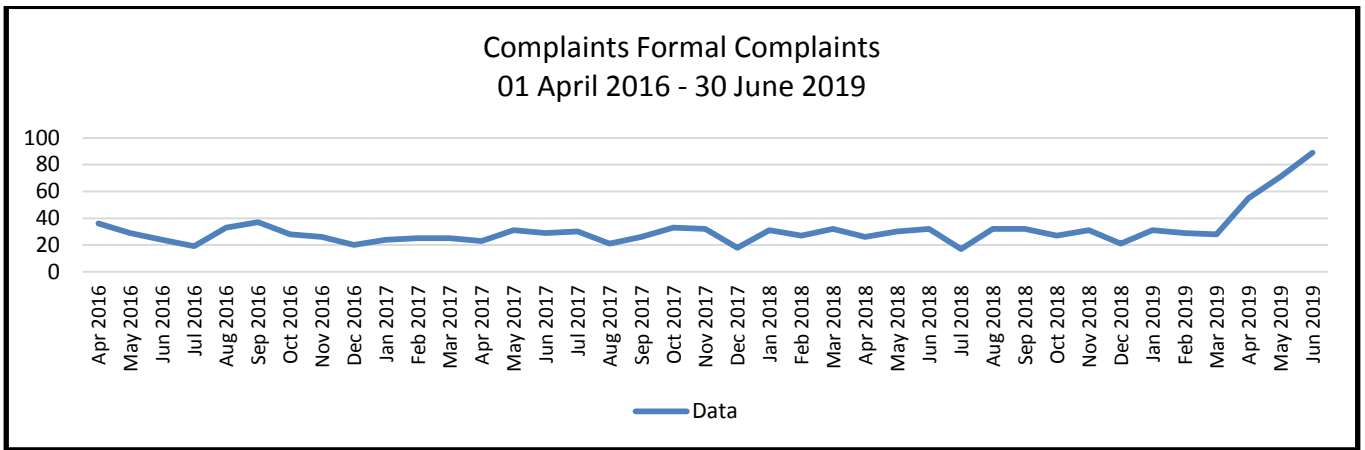


Chart 1: Complaints received since April 2016

Chart 2 below highlights the increase in formal complaints and decrease in informal complaints during Quarter 1. Also it demonstrates the increase in complaints overall with the complaints from the Bridgend boundary change being included.

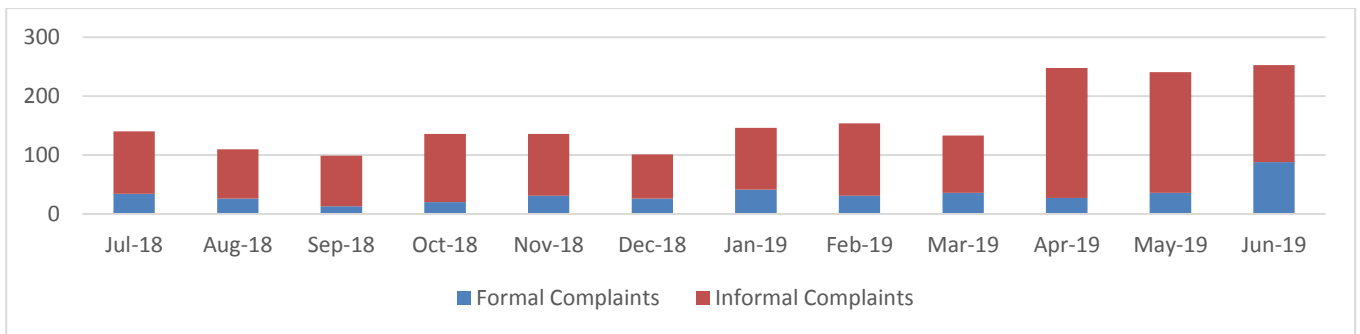


Chart 2: Number of formal and informal complaints received

It should be noted that although complaints often relate to several issues, only the primary reason for the complaint is recorded. The categories are recorded based on the patient experience when the complaint is received and not on the eventual outcome following investigation. A large proportion of formal complaints relate to three main categories– a breakdown for those received between 1 April and 30 June 2019 are reflected in the chart below:

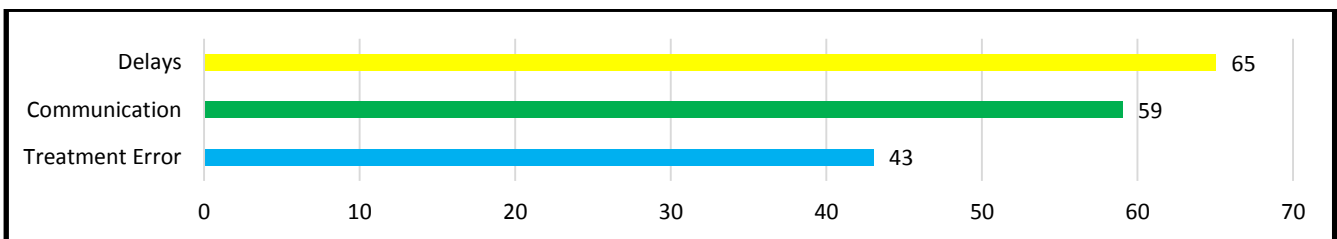


Chart 3: Types of complaints received – top 3 received

Further scrutiny of the top 3 types of complaints received identified that cases relate to:

- **Delays** in receiving treatment and waiting times. The numbers recorded for each site are 16 Prince Charles Hospital (PCH), 31 Princess of Wales (POW) and 8 Royal Glamorgan Hospital (RGH). Specifically the complaints relate to waiting times for orthopaedic surgery, test results not being shared with patients, which includes radiology results and delays with CAMHS appointments.
- **Communication** between staff and patients, the numbers recorded for each site are 5 PCH, 36 POW and 8 RGH. This includes patients not being advised of their care plan and the details of their conditions.
- **Treatment Errors.** The numbers recorded for each site are 10 PCH, 11 POW and 12 RGH and covers a number of clinical areas including A&E, Mental Health and Maternity Services.

3.1.2 Compliance with Putting Things Right (PTR) Timescales

During Quarter 1, 139 formal complaints cases were closed, 94 of these were closed within 30 working days. The overall compliance with the 30 working day target was 70%. This significant improvement in response times is due to the changes in reporting as outlined in 3.1.1 above.

Area	Number			
	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20
Total number of formal complaints being managed	108	100	141	144
Total Number closed	73	75	110	139
Compliance with 30 working day target (closed Cases)	21%	23%	22%	70%

Table 1: Compliance with PTR Timescales

These improvements in compliance are also highlighted in the chart below.

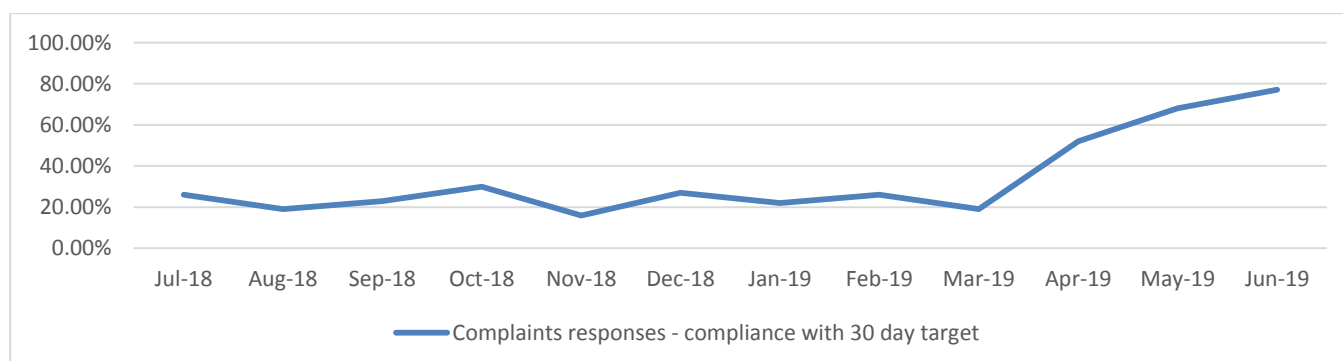


Chart 4: Compliance with 30 Working day target for closed complaints

At the end of Quarter 1, there were 144 formal Complaints which were 'ongoing' i.e. in the process of being managed, of these 70 complaints were overdue. These relate to the Acute Medical & Surgical Directorates.

Quarterly Patient Experience reports which outline all of the individual Directorates' service user feedback and performance against Putting Things Right requirements is produced by the Concerns Team and distributed to the Directorates to be shared at their Clinical Governance and Clinical Business Meetings.

Lack of complaint responses are escalated to the Directorate leads and where no progress is made this is then escalated at a corporate level to the Executive Director of Nursing, the Medical Director or the Executive lead for the area.

Internal assurance in relation to the management of complaints is undertaken by the Concerns (Complaints) Scrutiny Panel. The terms of reference for the Panel are currently being reviewed. Following the establishment of the sub groups of the Quality, Safety & Risk Committee monthly exception reports will be submitted to assist with the triangulation of concerns information.

3.2 Patient Safety Incidents

3.2.1 Serious Patient Safety Incidents

A total of 66 serious incidents were reported to Welsh Government between the 1 April and 30 June 2019. The trend of serious incidents reported since the 1 April 2018 is provided below.

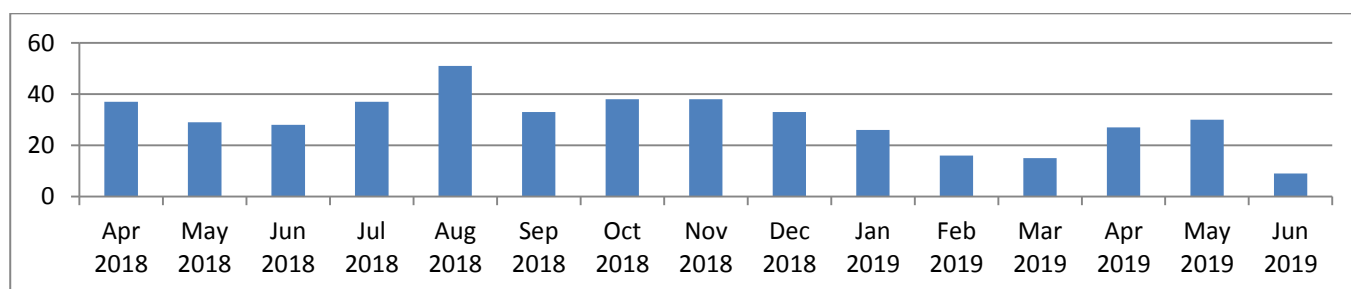


Chart 5: Serious Incidents Reported to Welsh Government

The highest number of incidents reported relate to the high risk area of Acute Medicine and Emergency Care specifically in relation to patient falls at Prince Charles Hospital and Ysbyty Cwm Rhondda (YCR).

All incidents relating to patients falling are investigated and an improvement project is ongoing at Prince Charles Hospital, supported by the Quality Improvement Team, which includes provision of falls related information to front line staff and more intensive nursing with checks undertaken every 15 - 30 minutes for high risk patients. At YCR the incidents are being investigated to identify the required improvements needed, however immediate safety actions have been completed at the time of the incidents occurring.

The number of incidents reported for Child & Adolescent Mental Health Services has increased, with a cluster of incidents occurring in April 2019. These incidents are related to the nature of the young people that are currently in-patients on the Ty Llidiard Unit. Discussions are ongoing with Welsh Health Specialised Services Committee (WHSSC) to inform the type of service to be commissioned from the unit.

The position in relation to Serious Incidents from the 1 July 2018 to the 30 June 2019 is summarised in the following table:

Time period	Quarterly trend			
	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20
New Serious incidents reported	120	109	58	66
Never events included in above reports	1	0	0	0

Table 2: Serious Incidents Reported to WG

The figures in table 2 above reflect the trend by Quarter, of note, Quarter 2 broadly reflects reporting that took place relating to retrospective reporting of serious incidents within Maternity Services. Quarter 4 reflects the refinement of reporting pressure damage which no longer requires the reporting of unavoidable damage, hence lowering the incidence. In addition to this, the serious incidents reported in Quarter 1, is reflective of the new Cwm Taf Morgannwg areas.

3.2.2 Review of Patient Safety Incidents

In relation to internal assurance, actions taken to support areas includes provision of information to the weekly patient care and safety executive catch up providing a mechanism to escalate concerns relating to incident reporting and investigation.

Following the boundary change, opportunity has arisen to review and identify good practice in relation to the Datix incident management system. There is ongoing work which is being supported by the Welsh Risk Pool to ensure consistency of the Datix system across the Health board.

In the future, Board may wish to consider the receipt of trend information in relation to incidents awaiting review and investigation in progress outside of timescales.

3.3 Inquests

An inquest is a formal investigation conducted by a coroner in order to determine how someone died. Inquests are held only in certain circumstances, such as where a death was sudden and the cause is unknown, where someone has died an unnatural or violent death, or where someone has died in a place or circumstance where there is legal requirement to hold an inquest, for example in prison custody or whilst sectioned under the Mental Health Act.

The purpose of an inquest is limited to establishing four key things: the identity of the deceased as well as where, when and how they died.

3.3.1 Regulation 28 Reports – Prevention of Future Deaths Report

The Coroners and Justice Act 2009 allows a coroner to issue a Regulation 28 Report to an individual, organisations, local authorities or government departments and their agencies where the coroner believes that action should be taken to prevent further deaths.

There has been one inquest concluded which has resulted in a Regulation 28 Report since the last report to Board. This report was issued to 5 Health Boards along with Welsh Government and relates to the process for making and receiving of referrals to the Neurosurgical Specialist Registrar. The concerns within the report identified that the current system is not fit for purpose, with inefficient delays, miscommunications and confusion occurring. In addition the report highlights that there is no back up doctor to field referrals if the on-call doctor is in surgery or dealing with an emergency. A response to the report is being coordinated by WHSSC.

The learning from Regulation 28 Reports is shared via the Directorate structures and the Listening & Learning from Feedback Newsletter. The Audit, Education and Quality Improvement teams also support the required actions for organisational wide shared learning and improvement.

3.5 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 4 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.

Performance for all Health Boards and Trust in Wales can be found at <http://www.patientsafety.wales.nhs.uk/safety-solutions-compliance-data>

4. **RECOMMENDATION**

The Health Board is requested to:

- **NOTE** the report.

Freedom of Information Status	Open.
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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 an 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. Uptake of training in this area requires improvement. 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

No. Patient Safety Alerts & Notices Name & ID	Issued	Progress update & Outstanding Actions	Executive Lead	Deadline for completion & RAG status
PSN049	09.04.19	<p>Health Board guidelines are in place, which incorporated the previously issued All Wales Guidance.</p> <p>There are a number of areas of risk for this notice which include:</p> <ul style="list-style-type: none"> • Lack of a coordinated approach and clinical leadership for tracheostomy within the Health Board. • Funding was issued to the Health Board in December 2018 for the establishment of a Tracheostomy Team (Band 7 Full time lead, Band 7 0.6 wte Physiotherapist, Band 7 0.6 wte Speech & Language Therapist). This team has not been established. • Staff currently delivering training within the Health Board have not received training which identifies them as competent to do this. They currently deliver based on the clinical experience. External training had been identified, although funding had not been agreed. Due to lack of uptake the day was cancelled. Options in relation to funding of training are currently being explored and the option of providing the training for trainers within the Health Board premises. Without this training no further training can be provided internally. An SBAR report is currently being drafted for the Head of Clinical Education. • A baseline audit is to be undertaken. Audit requirements added to Corporate Audit Forward Plan (Tier 2). 	Medical Director	<p>01.07.19</p> <p>Assessment currently being undertaken to determine date of completion.</p>