Appendix 3:

Learning From Events Reports: a spotlight on submission to WRP and actions to improve position and address the risk of penalties/non-reimbursement of costs associated with Redress and Claims.

Improvement to quality and safety in healthcare is aligned to learning which flows from case investigations, and the LFER (Learning From Event Report) provides a framework for regulators and inspection bodies to gather assurance that appropriate improvement has been implemented.

The Health Board is required to submit a signed LFER within **60 working days** of the **decision to settle a case**. For Clinical Negligence & Personal Injury claims, the decision to settle a case is identified as the point when the Health Board agrees to proceed to settlement. This includes making an offer or accepting an offer to settle or to admit liability. For a case, which is lost at trial, the trigger for the Learning from Events Report is the date that a trial judgement is received. For redress cases, the decision to settle a case is identified as the point that a *Qualifying Liability* is communicated to the complainant or representing solicitor.

All cases considered for reimbursement by the Welsh Risk Pool (WRP) will be scrutinised for evidence of the lessons learned and improvement actions taken by the Health Board. Reimbursement (both interim and final reimbursement) will be **deferred** until the WRP Committee is satisfied with learning and the actions taken in a case. Where reimbursement payment is deferred due to outstanding information, the Health Board will be notified of this decision. The Health Board should ensure that the information requested is submitted within **two calendar months**. Where the information requested has not been provided within **six calendar months**, the request for reimbursement will be struck out by the WRP Committee and reimbursement will be 'permanently deferred'. Permanent deferral results in no further consideration by the WRP and a subsequent financial loss for the Health Board as a consequence of non-reimbursement of costs incurred for the claim.

In exceptional circumstances, the Health Board can obtain an extension from the WRP for delay in submitting an LFER to allow further evidence of learning to be provided.

1. What should an LFER include?

- The LFER needs to provide a sufficient explanation of the circumstances and background to the events, which have led to the case, in order that colleagues who are scrutinising the report can identify the links to the findings and learning outcomes.
- Supporting information, such as action plans, expert reports and review findings may be appended to the LFER to evidence the learning and improvement made as a consequence of the case investigation. This evidence should all be managed and available via Datix.
- The LFER must be signed by an appropriate senior staff within the organisation in accordance with HB procedure.

2. Current Position (June 2022)

The table below gives the current LFER position for both the historic cases and the newly triggering cases.

		Due before 31st Jan 2022 (historic)	Due from 1st Feb 2022 (newly triggering)	Total Overdue
a	Open Cases on Datix	112	33	145
b	Nu LFER submitted (% of total cases (a))	45 (40%)	27 (82%)	72 (50%)
c	Red Deferred	19	2	21
d	Amber Deferred	41	3	44
e	Further info requested	7	1	8
f	Nu of LFER submitted without learning (% of total submitted (b))	27 (60%)	17 (63%)	44 (61%)

Of the 112 historic cases, **94 (84%)** need further work, as they are either red or amber deferred or they have been submitted without learning to obtain a 6 month deferral period of extra time to gather evidence.

Of the 33 newly triggered cases, **23 (70%)** need further work, as they are either red or amber deferred or have been submitted without learning to obtain a 6 month deferral period of extra time to gather evidence.

Of the red or amber deferred cases, **38** have been identified by Welsh Risk Pool as exceeding the 6 month deferral period and have been recommended

for **permanent deferral**. These cases may potentially act as a blocker for further reimbursements for the specific specialty.

This is a significant risk to the organisation in terms of financial penalty, reputation and demonstration of action, improvement and learning to prevent future harm to patients and colleagues.

Without consideration to demographics and other acuity measures, Cwm Taf Morgannwg Health Board are significant outliers in comparison with other Health Boards in relation to numbers of due, deferred and incomplete LFER's.

3. Urgent action required

The 38 cases that have been identified by WRP for **permanent deferral** due to lack of sufficient evidence of learning, are being prioritised for completion and submission to WRP before their next committee meeting on 20th July 2022.

If these cases are not submitted, it will mean that the Health Board will not be reimbursed for the total cost of the claim or redress and the Health Board will bear the financial cost. They will also act as a blocker for any further reimbursements for that specific specialty. The central teams are supporting the ILGs/CSGs with these cases.

Immediate actions already in progress and planned:

- Senior support from Corporate, MC & RTE ILGs is being assigned to prioritise this effort.
- Clinical Executives to meet with the Clinical Lead and Management team for all relevant Clinical Service Groups to ensure ownership and accountability.
- Learning from Events Shared Learning day to be planned and led by Executives.
- Cases will be grouped and thematic learning will be identified to drive shared learning and improvement and mitigate the risks of financial exposure of the HB.
- Care Groups will present top learning themes in their specialty areas and organisational top themes will be identified and considered from patient safety incidents/complaints

4. Financial risks

The total payment risk to date (including redress) of the 38 cases highlighted by WRP is approximately £16 million.

5. Future management of LFER's

There is much activity in place and planned to prevent delayed management of LFER's for current and future claims and redress. The Health Board's central prioritisation of quality care, patient and staff safety and experience, is a strategic and cultural driver in ensuring avoidable harm does not occur; that incidents are managed effectively; that learning and improvement are fundamental to our ways of working, and that PTR processes are correctly followed and monitored.

- **Incident Management Framework & Toolkit**

In line with new National reporting requirements the Health Board has launched a comprehensive incident management framework and toolkit which supports colleagues from reporting incidents through to Learning From Events Records, family involvement, creating a safety II environment and being aware of human factor errors and psychological safety issues. There is a strong emphasis on ensuring Datix is used consistently as a conduit for all incident management, investigation and progress, action plans and uploading of evidence. This will ensure that any future requirements for LFER's, or to provide evidence to any other external bodies, will be readily available to the claims and redress teams as well as providing assurance to the Board of learning and improvement. Audit cycles will ensure that high standards are maintained.

- **Incident Investigation Training**

To accompany the new incident management framework the Health Board has updated its previous RCA training package and launched regular investigation training in June 2022. This training will facilitate an accredited, consistent, high standard of investigation and measurable action planning to improve patient safety and experience. Again, there will be significant emphasis on learning and effective use of Datix.

- **Data**

We have established the shortfalls in the compatibility of Datix to permit visibility and interrogation of LFER data. This is in addition to the issues in relation to effective organisational use of the system to manage the requirements of PTR and evidence learning and improvement for LFER's. A solution is being sought nationally and will be in place by July 2022. Clarity in relation to each case will facilitate a greater ability to risk stratify LFER progress. Resource to support business intelligence from the Datix system is crucial and is being identified through the operational model changes.

- **Listening & Learning Framework**

This framework is currently in draft and will be rolled out in September 2022. The aim of the learning framework is to promote a culture which values and facilitates learning and in which the lessons learned are used to improve the quality of patient care, safety and experience.

This Listening & Learning framework demonstrates how learning will be identified, disseminated and implemented in practice, in order to facilitate and embed a culture of appreciative enquiry and continually improving health care services.

The Learning and Improvement Framework adds a strategic approach to support the organisation to learn lessons from a range of internal and external sources, and to use this learning to share knowledge and create opportunities to develop excellence in practice.

All investigations, reviews and audits should have a resulting outcome focussed, measurable action plan. The majority of these can be pulled together in a composite plan that is monitored by the Listening & Learning Forum. Review dates are identified by the various groups to revisit or re-audit specific actions to identify how progress has been made and what difference this has made to service quality, safety, experience and practice. This is a key element of measuring impact. The virtual repository of organisational learning provides evidence of actions and improvement and can support any request to demonstrate effective learning both for colleagues and teams within the health board to make changes to their own work, but also for any external requirements such as LFER's, HIW or PSOW.

- **@SafetyCTM, Patient Safety Clinics & Learning Events**

@SafetyCTM and Patient Safety Clinics, run by the central team provides a regular opportunity to reinforce and support processes and opportunities for learning and improvement. Learning Events are used to provide opportunities to share learning from events to a wider audience and an organisational patient safety and learning day is planned for summer 2022.

- **New Operating Model – Improving Quality Governance, Patient Safety & Experience**

The model proposes a Central Quality Governance Team which supports each of the care groups with a similar model to manage and optimise patient safety incident management and investigation, complaints, compliments, and Putting Things Right regulations work, patient experience, mortality and harm reviews, patient safety solutions, external action plan reviews, quality improvement and faculty advocates. Care Group Quality Governance teams will be centrally managed in order to maintain equity and consistency and strengthen resilience. The current executive and senior leadership team supported by the central patient

safety team and the concerns and legal services team, will retain their core functions to provide pan-organisational strategic direction, leadership and oversight in compliance with legislation and regulation, quality planning, quality improvement, quality control and assurance, and in managing risk.

There will be an identified responsibility within the governance team for the timely completion of LFER's within a Care Group, and the requirement that LFER's are a standard agenda item at the Care Group Quality Governance, Safety & Experience meeting, with upward reporting to Quality & Safety Committee through the dashboard reports on a bi-monthly cycle.

Please note this briefing as a summary of current status in relation to LFER's and plans for strategic and operational improvements.

LFER figures can change daily with submission of LFERs and panel WRP panel approvals.