THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG CYMRU

Briefing for:	National Assembly for Wales Health and Social Care Committee.
Purpose:	Further information for the Health and Social Service Committee Inquiry into the NHS Complaints Process in Wales
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Date created:	22 July 2014.

Introduction

The Committee requested additional information be provided in relation to examples of how the NHS gains feedback from people who use or are close to services, other than the complaints process. The information below provides a summary of the approach adopted across Wales and highlights some specific examples for the Committees consideration.

The NHS Service User Experience Assurance Framework, originally developed in Cardiff and Vale UHB, has been used as a basis in all Health Boards quality and patient experience planning arrangements. The example below is taken from the Cwm Taf Health University Health Boards patient Experience Plan.

"Real Time"	"Retrospective"
Short surveys can be designed and used to obtain views on key patient experience indicators whilst patients, carers and service users are in our care (such as in hospital) or very shortly afterwards (such as on discharge or immediately after an out patient appointment). Results can be fed back to clinical teams and patients quickly and incorporated into the clinical dashboards.	**Postal surveys** can be used after discharge or a clinical encounter in another setting to gain in depth feedback of service user experience. They can also incorporate health outcomes measures and used in all settings, including primary care and the community.
"Proactive/Reactive"	**"Balancing"**
Permanent and temporary surveys for patients, service users, carers and citizens can be permanently hosted on Health Board and Trusts web sites. They can be used in two ways: to allow patients, carers and families to express structured views at any time; to	**Patient stories** can expand on and provide colour to the qualitative and quantitative information that comes from the other methods and can be useful when small numbers of patients are involved.

allow the Health Board to seek views on specific issues from the wider community. Health Boards and Trusts can also **commission surveys** on areas of interest and importance, sometimes in collaboration with other stakeholders.	**specific patient groups,** who meet to share experiences, provide advice on service delivery and developments and provide mutual support. **"3rd party" surveys** – several agencies also survey patients, carers and families about the services they receive.

There are a plethora of examples of where feedback is gained in relation to the experience of those in receipt of services for every Health Board. Feedback mechanism extend beyond hospital settings and seek to ensure a breadth of services and patient groups. Some examples are provided below.

Velindre NHS Trust

In Velindre Cancer Centre a group of people (multi professional) have been identified to undertake monthly face-to-face patient experience surveys. We aim to complete 50 surveys each month across various ward and out-patient settings. Patients are invited to provide feedback about their experience in that care setting on that day. The strength of this approach allows for immediate concerns/problems to be addressed by the person conducting the survey in conjunction with the relevant service lead on the day. Overall findings are collated into a monthly report detailing both quantitative and qualitative information, and this is made available for patients/carers as well as the teams/departments in Velindre Cancer Centre and the Nurse Director/Chair of the Trust (plus others). We also produce 'you said, we did' posters as part of this process.

Powys teaching Health Board

Powys teaching Health Board's Improving Patient involvement and Experience Group has established a broad range of feedback mechanisms. These include patient/carer stories at Board, focus groups, participation of individuals who use services or are close to them in formal Partnerships, amongst others. During 2013-14 focused on the further development and implementation of the NHS Experience Questionnaire.

Powys School Nursing Service: The service decided to carry out an NHS Experience Questionnaire exercise with students after following school based immunisation sessions.

The standard questionnaire was adapted as many of the questions were not relevant to the client group. The school nursing service clients were been seen in educational settings not health settings.

The questions that were used were:

1. Did you feel that people were polite to you?
2. Did you feel that you were listened to?
3. Were you given all the information that you needed?
4. Was there anything particularly good about your experience that you would like to tell us about?
5. Was there anything that we could change to improve your experience?

40 questionnaires were completed, the feedback was broadly positive and helped the school nursing service reflect on what further steps they could take to improve the service.

Aneurin Bevan University Health Board

Real time feedback: The Health Board has other approaches to gather patient views in real time, some of which are aligned to 'Transforming Care' such as Leadership Rounds, 'Graffiti Boards' used in

Maternity Services, 'You Said:We did" Boards in general Ward settings and Patient Diaries in ITU (4). All of these enable patients and service users to offer views/opinions as to their experience, with the opportunity for the service to visually identify what has been done as a result of feedback.

CHAaT: A further innovation in real time is the Care Home Ask & Talk (CHAaT initiative). This service is unique in Wales and involves a partnership approach between the Health Board and the NHS Retirement Fellowship and aims to improve the experience of people living in care homes. The initiative was a runner up in the Patient Experience Network Awards and has won an NHS Awards 2014.

Sage and Thyme: This work was a partnership between Macmillan Wales and the Specialist Palliative Care Team in Aneurin Bevan University Health Board, to enhance communication skills for staff and improve patient experience. MacMillan supported three members of the Health Board specialist palliative care team to be trained as "Sage and Thyme" facilitators.

The programme was originally aimed at multi professional staff caring for patients in receipt of palliative care. It soon became apparent that the course was applicable to all professionals who came in contact with people with concerns/distress. The client group is anyone with concerns/distress/unmet emotional and psychological needs.

Cwm Taf University Health Board

Dementia Carers Focus Group: patient experience initiatives are incorporated into the quality improvement projects within the CTUHB Annual Quality Delivery Plan to monitor feedback and measure outcomes. Dementia is one of the key areas, the experiences and opinions of patients with dementia and their carers are vital to ensuring services are planned, delivered and reviewed with the perspective of the service user at the centre. Recent engagement with local Dementia Carers Group has been undertaken. The Group were very keen to speak about their experiences particularly around diagnosis and support offered at the time of diagnosis. There was a mix of men and women, dementia sufferers and carers. The youngest person with dementia was 52 and was diagnosed three years ago.

Skin Cancer Patient Satisfaction Survey*:* The aim of the survey was to evaluate overall satisfaction of patients with the quality of service provided in the treatment of skin cancer by the Maxillofacial Department. The survey focused on three key areas, these being:

- Key aspects of the patients journey
- Representative of both Units at Prince Charles Hospital (PCH) and Royal Glamorgan Hospital (RGH)
- To identify any shortfalls and implement changes.

Questionnaires were sent to 100 patients following treatment of excision biopsies of confirmed or suspected Non Melanoma Skin Cancer. Overall 68 questionnaires were returned 70% from PCH and 66% from RGH. Patients continue to express a high level of satisfaction with most aspects of the service and areas for improvement were highlighted.

July 21st 2014.

ABM University Health Board:
Further Evidence for the Health and Social Care Committee Inquiry into NHS Complaints

ABM University Health Board accepts fully the themes that are contained within the report. These resonate with the Health Board's analysis that triggered a full review of the Board's complaints processes earlier this year. Significant changes have been made already but we recognise there is still work to do to create the culture across all our services where patients and their loved ones feel confident, are encouraged to and know how to provide immediate feedback (whilst having the care and / or treatment) on our services so that we can take immediate action and work with our patients and their loved ones to resolve any issues.

The approach taken by the Health Board was highlighted to the Committee on the 16th July 2014 as 'good practice'. This involves:

- Strong direct clinical leadership for concerns handling & patient experience, provided by an Assistant Director of Nursing and
- Review of the construction of the central concerns team:
    - strong clinical leadership provided by a senior nurse
    - bringing together legally trained, experienced complaints and nursing staff to form the team, with access to medical staff (dedicated sessions being planned)
    - Increasing the resources to meet the demand (to work to eradicating current backlog and ensuring complaints resolved within an appropriate timescale). Given the complexity and breadth of the Health Board, complaints are frequently complex and involve a number of services/hospitals/primary care areas.
    - Ensuring all staff are supported, developed and fully trained and have the required skills and aptitude.
- Clinical triage by Assistant Director of Nursing or Senior Nurse, facilitates immediate escalation / action in relation to possible serious concerns or trends
- Ensuring a patient-centred approach to complaint resolution (care & treatment related complaints): immediate contact made; face to face meetings offered at outset and if not able to resolve at that level to receive the investigation findings
- Strong Board level commitment to system change
- Health Board-wide programme to create the environment where all patients are encouraged to, and given the means to provide immediate feedback of their experiences so that issues can be 'nipped in the bud', good practice shared and confidence in the system developed. This involves a multitude of activities including: 'in our shoes events'; 'see it say it'; 'friends & family test'; 15 step challenge undertaken by Board members; all-Wales Patient Experience Framework surveys; use of QR codes, kiosks, internet to provide feedback; Ward

Sisters / Charge Nurse & Senior Nurse shifts reviewed to work evenings & weekends to go around and meet visitors.

- Concerns clinics held monthly at four main acute hospital sites to provide patients and their families an opportunity to meet with a Board Director / or Chief Executive and clinician to discuss their concern
- Skilling up front-line staff to resolve issues as they arise through a Health Board-wide local resolution & customer care training programme
- Procurement of two enhanced, patient-focussed technical information systems: SNAP 11 web based patient experience system; and all modules of the Datix web 12.3 Patient Safety system that is fully integrated with the electronic staffing record & patient administration system. These will enable significantly enhanced analysis with 'real time' dashboard reporting from service delivery level to Board.
- Strengthening accountabilities within the Health Board's organisational structure for the experience of patients and complaints

Key Ongoing Challenges:

- Increasing numbers of requests to re- review previous complaint investigations as a result of media attention

PRIMARY CARE COMPLAINT DATA

Based on our data, as of 21st July the Health Board received a total of 1581 formal concerns in the period 1st April 2012 - 31st March 2013

Of these 24 were recorded as formal concerns against Primary Care, 1.52% of the total of complaints.

The breakdown is:

▪ Dental Practices	3
▪ General Practitioners	18
▪ Nursing Home	3
▪ **Total:**	**24**

The primary care figures are only those complaints that have been made to the Health Board and not those sent directly to and managed by the practices themselves.

Report for the Welsh Government
Response to the Evans Report
July 2014

Complaint numbers	
Formal Complaints	**1123**
GPs **27 of these were investigated by the Health Board - remainder by GP practices. This doesn't include the complaints that go straight to GP practices that we don't know about and which they deal with themselves.**	**103**
Informal Complaint	**719**
AM/MP correspondence **These are the AM concerns that haven't gone through the PTR process but are responded to in 10 days**	**366**
Totals:	**2311**

Good practice

Central PTR Team

Training and Toolkit

Training programmes across the Board is now being linked to the electronic staff record and POVA and disciplinary investigation skills.

An intranet resource has been established which includes a toolkit to support investigating officers.

CEO Sign off

All formal responses are seen and signed off by the CEO.

Access

Concerns can be raised in person, by phone, by letter, via a form on the internet or 24 hours a day via email.

Redress/Duty of candour

The Redress panel is well established and meets 3 weekly with consultant attendance to present their cases.

Learning Committee

A learning committee with senior member of each division is in place and produces a learning bulletin with key lessons following each meeting which is distributed across the Health Board.

Key Challenges

- Infrastructure and resources
- Independent advocacy at point of contact
- Celebrating positive experiences is not well publicised
- Closing the loop and evidencing actions taken is challenging

Prepared by Jane Dale Assistant Director ABUHB July 2014

BCSU HEALTH BOARD ADDITIONAL INFORMATION REQUESTED IN RESPONSE TO THE EVANS PTR REVIEW REPORT

Complaint Profile Activity:

2012 / 2013:	**Secondary Care – 1446**	**Primary Care - 131**
2013 / 2014:	**Secondary Care – 1609**	**Primary Care – 132**
2014/2015:	**Secondary Care – 477 to date**	**Primary Care - 41 to date**

June 2013

- Organisation recognised significant concern with managing Concerns (Complaints and Serious Incidents)
- HIW/WAO Report expressing concerns around Board Governance arrangements, but also including Complaints/Concerns

July 2013

- New Nurse Director commissioned review of Concerns within organisation

September 2013

- BCU recognised the need for additional support, and interim support brought into organisation

November 2013

- A baseline review position of the extent of the backlog Complaints/ Serious Incidents
- Established interim objectives relating to the baseline position to focus on Complaints and Serious Incidents

December 2013

- Letters sent to Clinical Programme Groups (CPGs) for their Improvement Programme

January 2014

- A process of tracking performance established
- Regular reviews with CPGs comprising:
    - Weekly reports on Complaints position
    - PTR updates to the Quality & Safety Committee and the Board
    - Governance & Leadership Delivery Board – clear project management and holding CPGs to account for timescales established

January to October 2014

- Undertaken Staff, Stakeholder and Public engagement about patient experience priorities in the development of the Quality Improvement Strategy (January – March 2014)
- Following PTR Review and Report (January/February 2014), a Business case developed for the resources required to increase capacity and timeliness of response to complainants. Resources agreed April 2014 for some key posts and further clarity on funding in June 2014
    - These key posts are now currently being recruited and will commence late September/October 2014
    - Additional support: Additional medical leadership support gained through internal secondment to provide clarity on Concerns/Complaints process and medical engagement for that process (January 2014 to September 2014)
    - Workshop held in June 2014 to agree a consistent process for Complaints & Serious Incident management (50 staff attended workshop representing Clinical Programme Groups and Corporate Concerns Team), and outcome – agreed Process Map (July 2014)
    - Training Section
        - "Bondsolon" have provided Complaints Training & Report Writing training twice in the last year and external experts have delivered additional Complaint & SI training

Conclusion: There is an ongoing Action Plan to ensure ongoing improvements and resolve current challenges and improve Complainant involvement – going forward. To meet the challenges we now have a consistent approach across all Clinical Programme Groups (Process Map) and the recruitment of Senior Investigating Managers will ensure that the challenge of complex complaint investigation and responses required for Complaints and Serious Incidents will be coordinated and tracked closely by the Senior Investigating Manager and they will be a key point of contact for complainants going forward - including timely response to PSOW concerns.

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Caerdydd a'r Fro / Cardiff and Vale University Health Board	AGENDA ITEM 3.4 6 May 2014

CONCERNS – DEVELOPMENT PLAN 2014 – 15

Executive Lead: Nurse Director
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SITUATION

The NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 specify how concerns must be handled in NHS Wales and primarily describes a process. Adherence to the regulations and performance management against the targets is essential. However, these measures do not necessarily ensure that the complainant's experience is a good one.

The manner in which NHS Wales handles concerns and complaints is currently subject to a 12 week review, which is being undertaken by Keith Evans, the former Chief Executive of Panasonic UK and Ireland, supported by Andrew Goodall Chief Executive Aneurin Bevan UHB.

The terms of reference for the review are to:

- Review the current process to determine what is working well and what needs to improve
- Consider if there is sufficiently clear leadership, accountability and openness within the process
- Identify how the NHS in Wales can learn from other service industries
- Consider the wider cultural 'patient' service ethos and how staff are supported to deal with patient feedback
- Identify how the NHS can demonstrate it is learning from patient feedback.

It is anticipated that the report will be published June 2014. It should be noted that publication of the findings and recommendations made in this report may necessitate a re-evaluation of the UHB approach to the management of complaints and the proposed plan.

At the recent open public event hosted by the Community Health Council in partnership with the UHB, the attendees' views and experiences were sought with regard to the complaints processes. Some of the issues they told us included:

- There is lack of information as to how to raise and concern
- That they did not know who to raise a concern with
- That they had limited knowledge of the role and function of the CHC
- That the concerns process was "exhausting"
- That the organisation was perceived as not learning lessons

This report sets out the current position regarding concerns management within the UHB. It also considers proposals to amend the manner in which the Health Board manages and learns from concerns in 2014 -15, and details the associated actions required to improve.

BACKGROUND

CURRENT MANAGEMENT OF CONCERNS

Informal Resolution

The Health Board is committed to promoting the informal resolution of concerns within 2 days of receipt as per the PTR regulations. All informal concerns are logged by the central concerns team when received via this route.

The additional use of 1.4 WTE Band 2 temporary administrative staff has ensured that informal concerns are logged without delay and has addressed the backlog.

2011/12 - 121 informal concerns 79% resolved in 2 days

2012/13 - 545 informal concerns 87% resolved in 2 days

2013/14 - 640 informal concerns 91% resolved in 2 days

Working with the CHC

The Health Board and Cardiff CHC meet bi monthly, in recent months Velindre NHS Trust and the Welsh Ambulance Services Trust have joined the meeting. This forum provides an opportunity to discuss issues, share information, and with each organisation, review active cases.

The public event informed us that when more than one organisation is involved, this often makes the process even more difficult for complainants to navigate. This meeting may present an opportunity to breakdown some of these issues and to make the process more seamless. As all parties consider that informal resolution is the preferred manner to achieve better complaints handling, this has led to the CHC often approaching the concerns team directly to discuss if informal resolution is possible.

The success of addressing issues early is seen from evidence within the "2 minutes of your time" surveys. These surveys demonstrate that patients are prepared to give positive and negative feedback to us whilst they are in our care. The immeadiacy of this feedback provides clinical teams with the opportunity to identify the issues early

and take action to resolve problems, before they become concerns. Increasingly it is seen that where issues are raised, actions are being undertaken with great sucess.

Public Services Ombudsman for Wales

The Ombudsman's office engages with the Health Board if they feel that a prompt local resolution is possible. The prompt local resolution can be a further meeting or a further written response. During 2012-13 the Health Board agreed 10 prompt local resolution with the Ombudsman's office, with the average amongst Health Boards in Wales being 9.

The Health Board offers meetings to the majority of complainants on receipt of a response. Currently members of the concerns team attend the meetings to either chair or to take and produce the notes of the meeting. The taking and developing of notes is a time consuming activity. It is proposed to trial recording concerns meetings, with the agreement of all parties. The Concerns Manager is currently reviewing the available software to ascertain the most suitable product to convert recordings into text. This would release a significant amount of time from the concerns team as, on average, the concerns team attend 3 complainant meetings per week, with the writing up of the notes usually taking approximately 3 hours.

Moving Forward

The Executive Director of Nursing has reviewed her portfolios and has transferred the concerns team to the remit of the Assistant Director Patient Experience. This will provide a platform for the learning from concerns and patient feedback to be amalgamated to better inform service delivery to improve the patient experience.

The purpose of the UHB Patient Experience Feedback Framework is to:

- Ensure that Clinical Teams have methods available to allow patients (and their families and carers) to provide feedback on the care they receive
- Allow speedy resolution of issues raised by individual patients
- Allow identification of key themes and trends arising from feedback of all types (including concerns) and the actions taken
- Provide assurance to the Board that the key components of the patient experience are being assessed and that action is taken to deliver improvements.

These aims complement the requirements of the PTR regulations and Standards for Healthcare. The concerns and patient experience teams are now working closely together to ensure that all feedback is reviewed together and that joint learning and improvement is achieved.

PTR has been in place for nearly three years and much of the initial progress was with regard to understanding and implementing the regulations fully. Performance across Wales has been primarily measured against the response rates for the different categories of concerns.

The outline work plan described is intended to not only ensure that response rates against targets are improved, but that the outcomes from concerns are positive. It is imperative that the complainant feels listened to, that action is taken and that the process feels positive as possible.

The key areas that will be addressed include:

- Ensuring ease of access to the process, the organisation will demonstrate that it welcomes feedback of all types access

With the ongoing implementation of the Framework for Service User Feedback (3) work will be undertaken to include awareness raising with the patient, public and staff. At the recent public meeting attendees told us that they were unaware of how to raise a concern. In response to this links will be made with the Communications team for their guidance in developing posters and marketing materials to increase awareness. This will include:

- raising the profile of how to raise concerns on the UHB internet pages
- information at the bedside on how to raise a concern
- advertisement of the free phone number to raise concerns and where appropriate offer of mediation and local resolution made
- the complaints process and what complainants can expect from the UHB
- consideration of suggestion boxes at wards and in department
- identification of staff who are "in charge" at ward and clinical level to whom issues and concerns can be raised.

This will ensure that our patients, relatives, carers and staff are aware of the importance that the Health Board places on all forms of feedback, and know how they can play their part in providing feedback or how to raise a concern.

A pilot of a PALS style service (drop in) will commence in early summer at University Hospital Llandough. The service will be provided by a member of the concerns team and a member of the Community Health Council. It is anticipated that the service will be offered during afternoons and at the commencement of visiting hours, on pre arranged days. The service will be located close to the hospital main entrance in the Information and Support Centre, and advertised in wards, public areas and on the UHB intranet and internet sites. Training will be provided for CHC members and concerns staff by the Concerns Manager and CHC advocates. The emphasis will be on early local intervention to resolve issues. Themes will be monitored and the impact upon formal concerns assessed. Following the pilot, the scheme will be evaluated and if successful, rolled out to the UHW site.

For the pilot the Concerns Team will support the sessions from the existing team, utilising IT access in the centre. It is anticipated that the development of PALS style drop in sessions will provide relatives and carers the opportunity to raise and discuss concerns at an early stage. In the coming year utlising this development, we aim to be in a position where issues are prevented, or at worst identified and resolved earlier. It is anticipated that data will show a trend of formal concerns reducing and informal concerns increasing.

- Robust training for staff in concerns handling and investigation

A training programme is vital to improve the quality of investigations and is being requested by the Clinical Boards. There is a need for a structured, rolling programme of training to support the Investigating Officers and the Clinical Boards.

It is recognised within the UHB that there is a need to ensure that from the outset a concern is scoped by the Investigation Officer. We need to ensure that staff are confident to engage with the complainant prior to undertaking the investigation to ensure that they are listened to and involved in identifying the key areas for investigation.

To ensure we are investigating what is of real concern it is proposed that all Investigating Officers should be mandated to contact complainants. This would ensure that the UHB is developing a new system with expectations that we clearly listen to complainants, investigate the concerns that they raise, maintains two way communications and provides meaningful accurate responses.

It is also imperative that the appropriate member of the Clinical Board reviews the concern. There are opportunities to address any grade 1 and 2 concerns informally and this should always be considered. Many concerns about communication for example could potentially be resolved with a phone call to the concerned person from the appropriate manager/clinician.

The learning from the recent Ombudsman's investigation has highlighted the need for an ongoing training programme and the Concerns Manager has undertaken some sessions with a range of Directorates focussing upon

- Concerns avoidance
- Engagement with the complainant
- Root Cause Analysis (RCA) methodology in relation to concerns—using the tools appropriate to the level of investigation required
- Response Writing
- Statement writing

Whilst legal services have presented sessions discussing qualifying liability; evaluations received from Health Board staff and Community Health Council advocates was extremely positive.

Whilst the process of undertaking investigations and managing concerns within Clinical Boards may be viewed as an additional responsibility. It is considered that this offers opportunity to review and reflect on its own services. Wider learning will be shared with other Clinical Boards as part of the data sharing processes.

However, in order for Clinical Board staff to support the Investigating Officers in the completion of investigations, a programme of training will be developed in collaboration with the Patient Safety Team, and implemented in 2014 - 15.

- **Learning from the data**

The Concerns and Patient Experience teams will work with Clinical Boards to identify and improve patient experience. The data will undergo thematic analysis, with actions agreed to be taken forward becoming an integral part of the process. This will provide opportunities to identify and target specific areas for improvement, with the learning shared at the Health System Management Board.

The public need to be assured that we, as a Health Board, are learning from the concerns raised. Whilst this information is shared through Board reports, a methodology will be explored to share complaint information and learning at a local clinical level across all wards, departments and localities.

- **Quality Assurance**

Little work has been undertaken to date to formally gain feedback from complainants on "what it felt like for them" and the extent to which the response allayed their concerns. There has also been little formal "Quality Assurance" of responses from outside of the UHB or across the Clinical Boards. The Patients Association have developed good practice standards (4) regarding the implementation of a systematic peer review of responses and will form the template for the assurance process. The review considers if a response is empathetic, were opportunities to resolve and meet with complainants identified? Feedback from existing panels is that peer and lay review of responses improves the quality and empathy of a response. It also focuses upon identifying the lessons learnt and monitoring of the compliance with agreed actions. It is proposed that working with the public, patients, complainants and clinicians, a citizens and peer panel will be developed in 2014 -15.

At a recent UHB Concerns Panel meeting there was much discussion regarding the internal processes for managing concerns. The panel agreed that:

- all concerns must be centrally logged regardless of author, this includes AMs/MPs, (this also reflects the views given at the public meeting)

- all Health Board response letters should reflect if an external organisation has failed to provide a response to our queries

The panel discussed the implementation of a system that has a combined central and local response with clear escalation guidance. This system could be aligned to the UHB Scheme of Delegation and Earned Autonomy Framework.

On receipt within the Health Board concerns are graded 1- 5. The All Wales grading framework is based on a risk matrix developed by the National Patient Safety Agency it has been used to assess and manage risks and incidents for many years. This approach has been built on to develop a framework for determining the level of investigation required in dealing with all types of concerns in order to promote a consistent approach across NHS Wales. The impact or harm experienced by the patient is always the overriding factor for grading concerns. The harm grading is dynamic in nature and must be considered throughout the investigation. Furthermore the consideration for the potential of litigation, regardless of the harm grading is also a feature within the criteria, as there may be situations where the grading of harm is low i.e. a grade 2, but there is indication there they will be pursuing a claim.

The panel's views were that there were opportunities to link the initial concerns grading to dovetail with the proposed model for change and the work with the CHC. For example, concerns logged centrally and graded 1-3, plus concerns where informal resolution was to be undertaken would be directly managed within the relevant Clinical Board.

High level grade 3 and all grades 4 and 5 would be managed by an Investigating Officer from the Clinical Board (or via a peer from another Clinical Board) and linked to a member of the central concerns team. This would ensure the Investigating Officer is supported by experienced concerns team member. The resulting methodology would provide Clinical Board ownership and ensure any potential risk to the UHB is mitigated via the central teams' management of the processes and outcomes.

In some exceptional cases it may be reasonable to consider in the initial instance, joint instruction of an independent expert and run this process parallel to an internal investigation. These investigations would be independent of Clinical Boards. This would provide for some complainants a level of confidence and objectivity in the concerns process.

The panel also agreed that the Board need to encourage the copying of letters to patients except where there were sound clinical reasons to prevent this.

The public meeting heard views expressed that the process was exhausting and that the UHB needed to proactively communicate with complainants. With the proposed changes dependent upon the grading of the concern either the Investigating Officer or the central team would be responsible for this function. CID2 data would allow the tracking of communication with complainants by Investigating Officers.

A further consideration to ensure complainants do not feel ignored or unclear about internal processes could be the development of Complaint Clinics. These could offer the opportunity for complainants to come and meet UHB staff to discuss their issues.

- Redress

At present the Concerns Team manage all redress cases. In many Health Boards redress cases are processed via a clinical negligence team. The Health Board has a single clinical negligence manager and therefore this was not an option, the concerns co-ordinators supported by the concerns manager, manage these cases.

Consideration is being given for the appointment of a Band 6 Redress Case Manager. The role could improve the process and engage with the Clinical Boards more effectively, especially regarding the lessons learned and actions taken. The retirement of the Clinical Negligence Claims Manager in August 2014, presents an opportunity to review the role and remit of this post.

There needs to be improved focus upon minimising costs with admissions of liability where appropriate, effective monitoring of costs throughout a case, and engagement of the Clinical Boards in the decisions regarding the progress of cases. This is occurring, but there is a need to become more universal and structured. This would

provide to the Board further assurance that central monitoring of the lessons learned and evidence of organisational learning is being undertaken.

Model proposed changes against available resources

Components of the proposed work will be absorbed within the existing concerns team structure. However, the current resource will not be able to undertake all that is required. With some resource there could be significant improvement.

The current structure does not offer any resilience to the UHB and is heavily reliant upon the Concerns Manager. A staffing review will be undertaken to consider the most appropriate posts and structure. Consideration during the review will be given to other models used within PTR teams in Wales. Of particular interest is one new Health Board structure which includes lawyers, medical and clinical staff. A revised appropriately resourced structure will ensure that the team is enabled to meet the needs of complainants and Clinical Boards, and provide resilience within the UHB.

It is envisaged that with appropriate resources in place the Concerns Team could undertake several new roles and functions which would improve the Health Board's processes and outcomes to concerns management. This would include:

- Provision of a comprehensive training programme targeted and delivered via a structured programme with key themes:
    - Concerns avoidance-early resolution, access to senior staff, identifying time to listen to patients and relatives
    - Staff awareness of the concerns process
    - Public awareness of the process
    - Public listening events
- Quality Assurance of responses via a citizens and peer panel
- Monitoring compliance of the lessons learned from complaints claims and personal injury claims
- A commitment to feedback to complainants within an agreed time frame and monitoring of compliance against agreed actions

At the public meeting hosted by the CHC and the Health Board in April, a commitment was given to arrange a further meeting in October. At this meeting the changes which are agreed internally and the work that will be driven forward could be demonstrated to assess whether we are meeting the needs and expectations of the public.

RECOMMENDATION

It is recommended that the Board:

- **DISCUSS** and **ENDORSE** the outline proposals identified in this paper.

Financial Impact	Failure to effectively manage and learn from Concerns can have significant financial impact on the UHB. The review of the current concerns team may reveal the need for extra funding.
Quality, Safety and Experience	Concerns are a measure of organisational efficiency, culture and effectiveness. They are a means of capturing some of the patients, relatives and visitors experiences. Reducing and improving our responses to concerns will improve the patient experience.
Standards for Health Services	This report contributes evidence towards demonstrating that the requirements of sections (b) and (c) of Standard 5 (Citizen Engagement and Feedback) are being met. Standard 23, Dealing with concerns and managing incidents, outlines the arrangements NHS Wales need to have in place to respond to 'concerns' with an emphasis on 'putting things right'.
Risks and Assurance	The Report mitigates against risks identified with the Patient Safety (2) and Patient Experience (4) domains of the Board Assurance Framework.
Equality and diversity	The way in which the UHB manages its complaints process needs to take into account the needs of people with the protected characteristics.

References

1. Welsh Assembly Government (2010) Doing Well Doing Better. Healthcare Standards for Wales.

2. Designing Good Together Transforming Hospital Complaint Handling Parliamentary and Health Service Ombudsman August 2013. http://www.ombudsman.org.uk/__data/assets/pdf_file/0008/22013/Designing_good_together_transforming_hospital_complaints_handling.pdf

3. Framework for Assuring Service User Experience. April 2013 http://www.wales.nhs.uk/sitesplus/documents/1064/Framework%20for%20Assuring%20Service%20User%20Experience%20-%20April%202013.pdf

4. Patient Association. Good Practice Standards for NHS Complaints Handling. (2013).

[Appendix 1]

PUTTING THINGS RIGHT

Background within the Health Board

In April 2011, the Welsh Government introduced new regulations to inform the management of 'concerns' (complaints, claims and incidents) within NHS Wales. Putting Things Right (PTR) aimed to streamline and improve the way that concerns are handled and ensure that the health service does as much as possible to put right mistakes and learn lessons to stop them happening again.

Standard 23, within Doing Well, Doing Better. Standards for Health Services in Wales (2010) (1) consider concerns and management of incidents. It also outlines the arrangements that organisations within NHS Wales need to have in place to respond to 'concerns'. The key principles are that concerns:

(a) Are reported, acted upon and responded to in an appropriate and timely manner;

(b) Are handled and investigated openly, effectively and by those appropriately skilled to do so;

Organisations must also:

(c) Offer patients, service users and their carers support including advocacy and where appropriate redress;

(d) Provide appropriate support to staff

(e) Learn and share lessons from local and National reviews to improve services.

In addition to Healthcare Standards, feedback from participants in research undertaken by the Parliamentary and Health Services Ombudsman for England (2) concluded that there needed to be:

(a) an open culture of feedback and improvement

(b) a focus on putting things right on the ward

(c) a move towards a collaborative approach to care and complaining (where the "complaint handler" and complainant work together to co-produce a response)

The PTR regulations, Healthcare Standards and the evidence from public and patient feedback provide a framework within which the UHB should work to ensure that complaints are received, investigated, responded to and learned from, whilst ensuring that the complainant is treated with respect. When the information from concerns is considered alongside other forms of patient feedback a full understanding of what it feels like to be a patient is gained. This should ensure that areas for improvement are identified and continually assessed.

At the time the UHB was configured in 2009, all concerns were managed within a paper based system. The recording and monitoring of the number of concerns was undertaken manually with paper records and files. This resulted in difficulties in managing the processes, was labour intensive and did not offer the data that was required to provide rigour and assurance to the Board. Much of the work over the past few years has been to ensure that this position is reversed and that the Board is in a position to understand the number of concerns, the methods of investigation and the time that they have been active in the system.

On the request of the UHB a review was undertaken by the National Leadership and Innovation Agency for Healthcare (NLIAH), in 2010. The review identified issues and opportunities to move the management of concerns forward within the Health Board.

The NLIAH review made several observations and recommendations which are detailed below with subsequent action taken.

- ***Issues and Opportunities***
- *There is a lack of timely and accurate performance information*
- *There is a need to finalise and implement a single mandatory system/process that is adopted consistently across all Divisions*
- *There is a requirement for a clear process for matters that are not classified as complaints*
- *There is a will, within each Division, to own their complaints and the resulting performance improvement*
- *Everyone would welcome a live electronic monitoring system and the introduction of the use of shared drives/folders*
- *Along with some training on letter writing staff would appreciate greater use of templates/guidelines for responses.*

Response

CID 1 and 2 (Complaints Information database), the Health Board has developed a database that can provide a list of active concerns, the number of days that they have been in the system, the investigating officer, when the next action is due and information can be from UHB to speciality level. The database also provides performance data.

The CID 2, launched from 1st April 2014, also allows measurement of further activity in the Concerns Team and the Clinical Board. For example, a complaint may have been responded to but remains in the local resolution process for a further meeting, or joint instruction of independent expert, legal advice and Ombudsman investigation etc. Each stage can be recognised within CID and reported upon.

- ***Standard letter guide***

  Staff would welcome guidance on the format, content and tone required within complaint response letters. This should include an introduction, each question set out with response, action taken as result of investigation and indication as to patient options if not satisfied.

Response

The Concerns Manager has worked closely with Divisions to provide feedback on the quality of response. This has led to the development of an interactive toolkit to assist in the management of concerns. This toolkit has been designed to assist the Clinical Boards in line with the authorisation process.

- ***Staff training***

  Staff development is required:

  - *to improve understanding of how to address complaints*
  - *to implement the process*
  - *to learn how to compile a satisfactory complaint response*
  - *To learn how to deal with complainants directly whether it be face to face or over the telephone.*

Response

The Concerns Manager provides training for staff on an ad hoc/requested basis. There is no further capacity within the team to develop and deliver a planned training programme at this time but is currently under review.

- ***Data and Information***

  All complaints need to be entered on the DATIX system, on the day they arrive and the acknowledgement letter drafted for signature.

  A shared drive should be created that holds individual files for each complaint. The Complaint Coordinators should input all details of each complaint onto a shared drive and inform the relevant Divisional Nurse, by email, that a new complaint has been received.

Response

The Concerns team have provided each Clinical Board with a shared drive where all concerns are held. All files are electronic and both the Concerns Team and the Clinical Boards have agreed templates for use to ensure compliance with key points of the PTR regulations.

- ***Development of the Redress Tracker***

Response

The Concerns team have worked with the finance team to develop a Redress Tracker Database which allows accurate monitoring of the costs regarding Redress cases and where the money has been spent. This is a shared database between concerns and finance.

- *PALS*

  Need to consider the value and potential for the implementation of a Patient Advice and Liaison Service (PALS).

Response

The development of a PALS style service is referenced in the main paper.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Ysbyty Athrofaol Cymru
University Hospital of Wales
UHB Headquarters
Heath Park
Cardiff, CF14 4XW

Parc Y Mynydd Bychan
Caerdydd, CF14 4XW

Eich cyf/Your ref:
Ein cyf/Our ref: MB-as-07-3840
Welsh Health Telephone Network:
Direct Line/Llinell uniongychol: [redacted]

Maria Battle
Chair

21 July 2014

[redacted]

Dear Nesta

Re: "Using the Gift of Complaints"

Please find attached details of the information you have requested on behalf of Helen Birtwhistle for the Health and Social Care Committee.

Yours sincerely

Maria Battle

MARIA BATTLE
Chair

Using the Gift of Complaints

Cardiff and Vale UHB very much welcomes the publication of "Using the Gift of Complaints" by Keith Evans and would like to take this opportunity to demonstrate our commitment to improving patient experience.

Number of concerns

The Committee requested information about the number of concerns received relating to General Practices and primary care. Within 2013 - 14 the UHB directly received 1760 complaints, These complaints are entered onto the Datix system against each area in which the issue arose within the eight Clinical Boards. We are therefore able to extract the proportion of primary and secondary complaints that are recorded in the relevant Clinical Board although not those received directly by General Practices if they have not been shared with the UHB by the General Practice or by the complainant.

For example from 1st April 2013 to 30 June 2014, the UHB received 455 complaints (this includes informal concerns) of these 32 were about Primary Care services of which 19 were within GP practices, 4 about Out of Hours GP services. Within Dental practices there were 3 complaints and 1 about Out of Hours' dental care. The remainder occurred in other primary care services such as Integrated Sexual Health. The data within this time frame does not change significantly over the year although complaint issues may be re categorised as the investigation unfolds.

On receipt of a concern the Nurse Director or Assistant Director of Patient Experience reads and grades each concern. Where appropriate, with the less serious or uncomplicated concerns, we aim to respond and address the issues raised within 24 hours. When successfully resolved these are then logged as informal concerns, otherwise they are logged as formal complaints. We inform complainants about the CHC or mental health or other advocacy services when we believe the complainant may need an advocate but we do not inform every complainant routinely about the CHC due to the resources of the CHC. Complaints are acknowledged by the UHB central concerns and complaints team. In 2013-2014 93.9% of complainants received an acknowledgement within 2-days but only 46.6 % of complainants received a response within 30 days. The central concerns and complaints team log the concern on the Datix system.

Currently the complaint is forwarded to the relevant Clinical Board who identifies an Investigating Officer, often at arms length to the staff or team subject to the complaint. The Investigating Officer has a responsibility to contact complainants directly, this contact has been mandated by the Board and is subject to spot checks by the central complaints and concerns team. The contact with the complainant is often ongoing throughout the investigation. The UHB has recently developed an Investigation Toolkit, to provide further guidance to Investigating Officers when conducting investigations as well as training. We also, where appropriate, agree with the complainant to jointly instruct external experts in accordance with Putting Things Right.

On completion of the investigation report, the Clinical Board approve the report prior to passing it to the relevant Executive Director. The CEO signs off all responses and

I am the complaints champion on the Board and chair a Concerns Committee. Serious complaints are reviewed at a weekly meeting of the Director of Nursing, the Medical Director and the Chief Operating Officer. Throughout the raising, investigation of, or on completion of the complaint process the UHB offers the opportunity for complainants and or families to meet with relevant health care staff.

The final written response provided to the complainant routinely offers the opportunity to contact the UHB should they remain unhappy or require any clarification. This letter also contains contact details for the Ombudsman's office.

Good Practice Examples

One of the key issues in Keith Evans report is culture, particularly the culture of lock down. Since coming to Cardiff and the Vale UHB two years ago the CEO has personally led an extensive listening exercise and based on this we have confirmed our values of honesty, integrity, respect, personal responsibility and kindness and why we exist "to care for people and keep them well" . Recruitment and appraisals ask for recent examples of kindness and through example and constant communication these values are emphasised. In response to what staff said we have created 8 Clinical Boards, through open recruitment, devolving responsibility and accountability and have a number of work streams to help transform the culture. In a large and complex organisation this is an ongoing challenge which has to be led by example by the Chair and CEO.

The UHB has an NHS Whistle Blowing Policy which is rarely used. As with the public the staff are the eyes and ears of the organisation. Following the Francis report I introduced and take personal responsibility for the "Safety Valve". This is a non bureaucratic way which encourages staff to take personal responsibility to intervene if they witness poor care and if for any reason this is not possible they can contact the Chief Executive or I personally. I meet with the staff who make contact, hold the executive to account, personally feed back the outcome and revisit to check the changes have been implemented.

It is also important to be seen. As well as the regular patient safety walkabouts and unannounced inspections the Vice Chair and I make unannounced visits in the evenings to wards to listen to front line staff, patients and carers, to support and get a sense check on how things are. The CEO regularly has lunchtime sessions with groups of staff to listen across the UHB. Our relationships with our staff representatives also offer opportunities to raise any issues that may have been reported to them and to accompany them on night shift visits.

In April 2014 we held a public meeting chaired and facilitated by Cardiff and the Vale CHC and in partnership with WAST and Velindre of randomly selected complainants to listen to their experience of the process and what needs to improve. A number of suggestions were made to improve the process and we are holding a further meeting in October 2014 so that the public can hold me directly to account for implementing those changes. Some of the participants have since become advisors to the UHB eg a dementia champion and we are exploring setting up a Citizens Panel to be part of quality assurance in the complaints process.

In addition the Board have been trained by Participation Cymru and we have commenced continuous public engagement meetings so that the public has the opportunity to raise issues, hold us to account, have a conversation and we are seen as a face, rather than" they" and "them". This is particularly important in the light of what Keith Evans described as being "under siege". It is an opportunity to listen, to build trust and to share some of the changes we have made and the challenges we all face. For example, many of the complaints in the winter of 2012/14 where about cancelled operations. Through intense work on patient flow, investment in RTT and our winter plan there was a 64% reduction in cancelled elective operations in the winter of 2013/14. Another example is our patient experience surveys and complaints raised the issues of blankets and 14 % of patients feeling cold. On investigation there seemed to be no correlation between the area in the hospital and the experience and feeling cold and this could have been condition specific. In response we piloted and then introduced new counterpanes, which are heavier than blankets, and are encouraging staff to actively ask patients are they warm enough. It is also important to share with the public directly the challenges we face in respect of the environment and bathrooms and décor so they understand why some are not of the standard we all would like. Further the UHB is bound by the rules of confidentiality in responding to media articles and can be perceived by the lack of detailed response as not being open and transparent. Public engagement enables the public to judge for themselves whether we are trustworthy.

In June 2014, a pilot commenced in University Hospital Llandough in partnership with Cardiff and Vale CHC. Twice weekly we have PALs style drop in sessions where CHC members and concerns team staff are present. They provide information and support, assisting when concerns are raised by patients, relatives and carers. This service has been well publicised and has resulted in not only physical attendance but phone calls to the concerns team where informal resolution has been successful.

The Nurse Director has recently realigned her portfolios, with the concerns department and patient experience being directly managed by an Assistant Director. This will now assist in the triangulation of all patient feedback gained either by the implementation of the National Service User Framework or via concerns processes.

We have begun working more closely with our local health partners, eg Velindre Trust and Welsh Ambulances Services Trust to develop further integrated investigations to benefit complainants and share learning between organisations.

Public Services Ombudsman's reports

All recommendations made by the Ombudsman are implemented within the UHB. A central overview is maintained, and issues which require Clinical Board implementation are driven forward through action planning, and are monitored by the relevant Quality Safety and Experience groups. As requested by the Ombudsman's office or HIW evidence of implementation is provided. By way of example we have implemented the stroke pathway which is monitored at Board level, whilst the medicine reconciliation programme is in place and being implemented.

Key Challenges

The Board will continue to respond to the challenges. We must provide more support and build on our education and training in clinical areas to ensure local resolution, and when investigations are required, ensure they are conducted in a robust, thorough and timely manner with appropriate outcomes for the complainants. We must also improve our compliance to the 30 day targets and this is recognised within the Clinical Boards. We recognise the need to increase the central resource and expand upon our PALs style service. This will be driven forward though our business planning processes. We are also considering a freephone number, mediation, information at the bedside, suggestions boxes in each ward, following up complaints with customer care satisfaction telephone calls and we will be working with our colleagues in NHS to explore national initiatives

I have attached for your consideration the paper that was presented to Board in May 2014 which provides more detail of Cardiff and Vale UHB commitment improving the concerns agenda.

MARIA BATTLE
Chair

Cwm Taf Local Health Board

Annual Concerns Report

2012-2013

Introduction

Cwm Taf Health Board values the views of patients and users of our service, and responds positively and openly to concerns raised about the services that we provide.

Cwm Taf Health Board deals with concerns in line with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 which came into force on the 1st April 2011. The principles of the Welsh Government *Putting Things Right* arrangements are to "investigate once, investigate well" and in order to achieve this, the Health Board has developed a range of policies and procedures which are designed to ensure that all concerns are investigated at an appropriate level and that patients and their families receive a full and open explanation of the findings. In this context, concerns are issues identified from patient safety incidents, complaints and, claims about services provided. As part of these regulations, Cwm Taf Health Board also determines whether or not an offer of redress should be made.

This annual report details the progress made against the Health Board's implementation of *Putting Things Right*, compliance with the response rates set out in the Regulations, together with an overview of the concerns reported through the process, namely complaints, patient safety incidents and claims, for the period 1 April 2012 to 31 March 2013.

The Health Board is committed to providing a single integrated and supportive process for people to raise concerns, which:

- Is easy for people to access;
- People can trust to deliver a fair outcome;
- Recognises a person's individual needs;
- Is fair in the way it treats people and staff;
- Makes the best use of time and resources;
- Pitches investigations at the right level of detail for the issue being looked at;
- Can show that lessons have been learnt.

Strategic oversight and arrangements for the handling and investigation of concerns

The Director of Nursing has been designated by the Chief Executive Officer, to be the responsible officer who takes overall responsibility for the effective day to day operation of the arrangements for dealing with concerns in an integrated manner.

Independent Scrutiny and Governance

To provide the Health Board with assurance on how concerns are being dealt with, effective corporate systems and processes have been developed, and continue to be improved upon in order to support excellent practice at the point of care. They assist the Health Board in

identifying and addressing risks, promoting innovation, and promoting continuous improvement.

Specifically, the Health Board has two concerns scrutiny panels which meet quarterly. The panels are both chaired by an independent board member to provide the strategic oversight for the Health Board's handling of concerns. The independent member is Mr Anthony Secular. The panels also have representation from other independent board members, Executive Directors, and the Community Health Council.

The panels take a strategic overview of the concerns process and trends, and assess the degree of effective management and quality of responses, through deep scrutiny in a sample of cases selected by non-officer board members. In addition, over the past year, the Panels have identified areas of high risk, which has initiated further work in order to improve safety and quality of care. Examples of improvements made as a result of this robust system of scrutiny are provided later in this report.

Training

In order to ensure that the Health Board provides staff with the skills and tools that they need to deal with concerns, a comprehensive training strategy has been developed. The strategy recognises that the level of training required by individual staff will vary according to their roles and responsibilities, based on the competencies required. The training aims to inform staff of two important aspects:

a. Informing staff about the **process and approach** - what to do in response to a patient safety incident, complaint, or claim.
b. **Sharing learning** from patient safety incidents, complaints, or claims, in a way that leads to improvements to care and services wherever possible.

The training framework consists of delivery on three levels, according to the role and level of responsibility inherent in professional staff groups:

Level 1 - Awareness

Level 2 - Operational

Level 3 – Expert

The Concerns Team has provided training during the year to a variety of staff groups, to more than 750 people (excluding nurse induction and corporate induction) including:

- Corporate induction groups (Level 1)
- Nurse induction groups (Level 2)
- GP Vocational Training Scheme (Level 2)
- Creating a Culture of Care attendees (Level 2)
- Doctors in training (Level 2)
- Targeted training to meet specific needs (All Levels)
- Targeted training in incident reporting and risk assessment (All Levels)

Concerns Statistics

The Health Board uses the Datix electronic system to record activity in relation to concerns. This is a database which facilitates regular reporting, and supports effective risk management through the identification of high-risk trends and themes.

When reviewing statistics in relation to concerns, it is important to examine the numbers in context – this includes the volume of clinical work undertaken within the Health Board to the population of Cwm Taf. Within this context, the overwhelming amount of care is delivered to excellent standards, and with high levels of patient satisfaction, as reflected on Page 14.

Statistics for 2011-12 reflect the following activity levels:

	Number of patient contacts
Outpatient Attendances	
New Outpatient Appointments	123,510
Total Outpatient Appointments	461,839
Outpatient Appts. with a Procedure	44,153
Discharges resulting from	
Elective Admissions	8,678
Emergency Admissions	46,759
Total Discharges	55,437
Emergency Care	
New A&E Attendances*	123,392
Total A&E Attendances*	134,824
Surgical Procedures	
Elective (including day surgery)	18,491
Emergency (in and out of hours)	3,479

* Note: this includes attendances at the Minor Injuries Units at Ysbyty Cwm Rhondda and Ysbyty Cwm Cynon.

Patient Safety Incidents

A patient safety incident is defined as *'any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS-funded healthcare.'* A total of 7,977 patient safety incidents were reported during the year. The Health Board reports all patient safety incidents onwards to the National Patient Safety Agency's National Reporting and Learning System (NRLS) on a monthly basis.

The NRLS provides six monthly reports which benchmark's Cwm Taf Health Board's position against other similar organisations. The reports give data on the individual organisation's figures and trends, as well as aggregated national data - the reports show that the numbers of incidents reported by Cwm Taf is the highest of all the Welsh Health Boards. The majority of the incidents reported (21.44%) resulted in no harm, or low harm, and it is well recognised that high reporting rates of incidents resulting in no harm or low harm, is a positive sign, associated with an

open culture and a willingness to learn from potential or actual errors.

Levels of Harm

The Health Board uses the National Patient Safety Agency definitions to define the levels of harm caused by patient safety incidents, as follows:

No harm	Impact prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care.
	Impact not prevented – any patient safety incident that ran to completion but no harm occurred to people receiving NHS-funded care.
Low	Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care.
Moderate	Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.
Severe	Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.
Death	Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care.

Table 1 shows the levels of harm of reported Patient Safety incidents for the year. Benchmarking has identified that the Health Board has a higher than average percentage of reported incidents that result in moderate harm – 21.44% in Cwm Taf compared with 9.8% across Wales. Urgent work undertaken has shown that this is largely due to reporting error – with staff wrongly assessing the degree of harm caused. Focused staff training is being delivered, and trends are being closely monitored, with a view to aiming for a reduction in this category by September 2013, in line with, or below, the Welsh average. It should be noted that the levels of harm relate to the immediate outcome **as a result of the incident**.

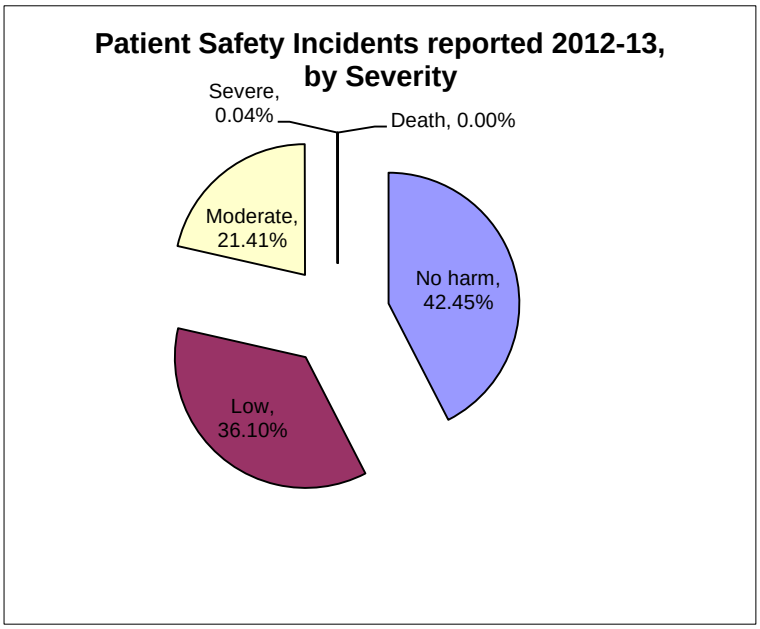


Table 1: Levels of harm

Table 2 shows the reported patient safety incidents by hospital department. It reflects that the number of reported incidents correlates with the activity levels, the acuity of patients, or high-risk procedures being undertaken in these areas.

These incident reports consist mainly of incidents where no harm or low harm occurred, as indicated in Table 1.

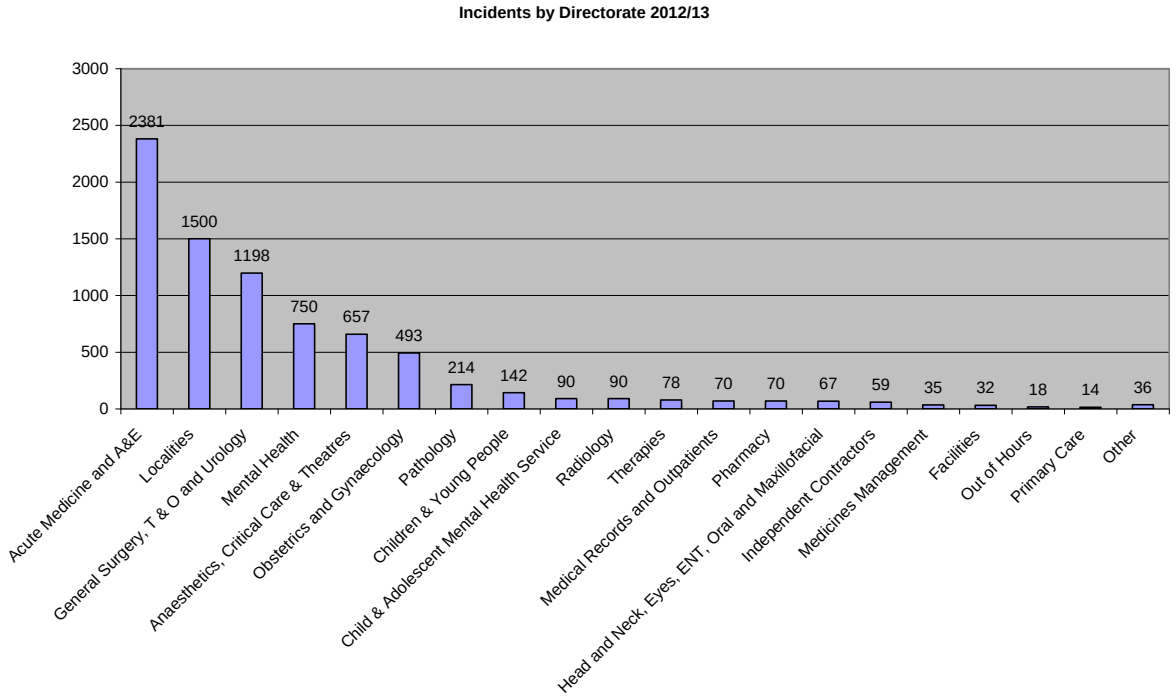


Table2: Reported Incidents per Directorate

Table 3 shows the type of patient safety incidents (Category) reported:

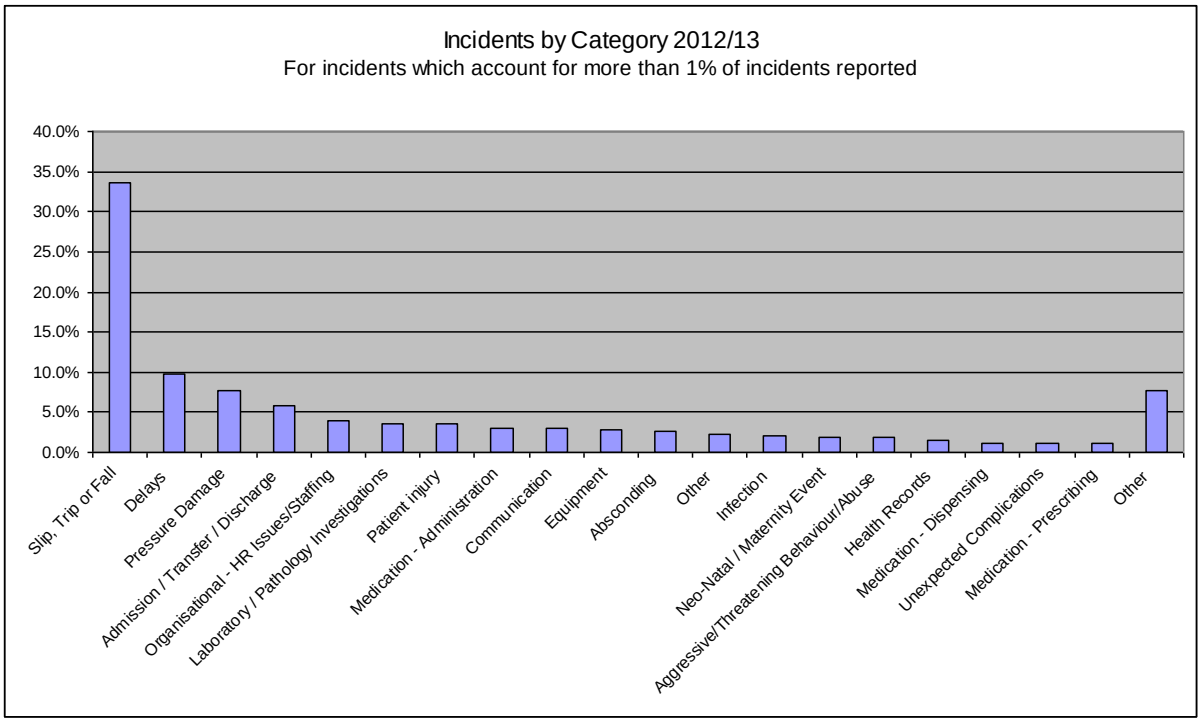


Table 3: Patient Safety Incidents by Type

The Health Board is required to submit details of 'serious incidents' to the Welsh Government. The reporting criteria are slightly different to the NPSA definitions (which relate solely to levels of harm caused), and include significant events where there is likely to be media interest, and unexpected deaths. The numbers of 'serious incident' reports to WG are therefore greater than those made to the NRLS. During the year, 46 such incidents were reported to the Welsh Government as shown in Table 4.

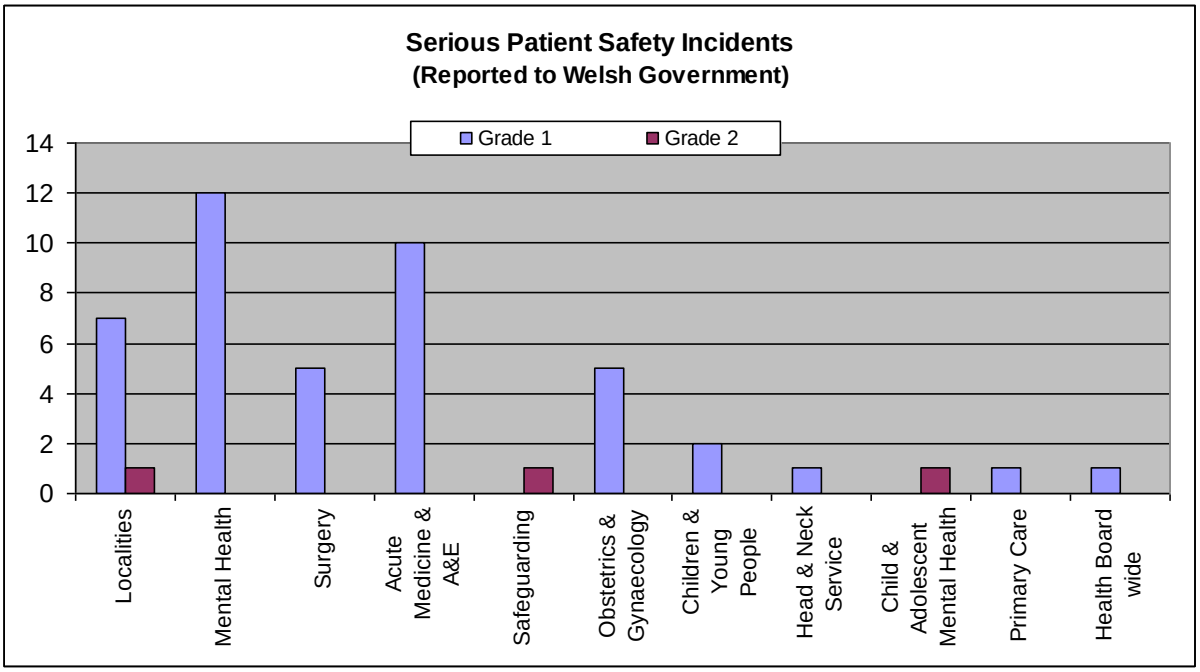


Table 4: Serious Incidents reported to Welsh Government

Complaints

Complaints – Process

A complaint is defined in *Putting Things Right* as 'any expression of dissatisfaction' about their care. Complaints can be first received at any place across the organisation, and not all complaints are resolved using the formal process.

In responding to complaints, the Health Board considers the whole of the patient pathway and complaints often relate to complex issues. Each person raising a concern is seeking an explanation of the care given to themselves or their relative and, in this regard, the Health Board considers that all complaints are founded, because of the experience of the individual.

- On the spot concerns

  Many complaints are resolved 'on the spot' by front line staff as they arise. Front line staff are encouraged to be pro-active in dealing with concerns that patients or their families raise as, often, the most important aspect of dealing with them is to resolve them to the

satisfaction of the person raising the concern as soon as possible.

- Patient Support Service

  Two Patient Support Officers work as part of the Concerns Team, one based in each of the two acute hospitals, who assist in resolving complaints speedily and close to the point of delivery. Their role includes meeting patients and their families, liaising with directorate staff and, where necessary, attending meetings to support patients in resolving their concerns. During the period April 2012 – March 2013, they dealt with 464, patients or families that required assistance, an increase of 30% on 2011/12.

  The Patient Support Service Officers are also involved in working alongside the Patient & Public Involvement Manager and regularly receive feedback through the 'Have Your Say' scheme, and liaise with directorate staff to identify opportunities for improvements as a result of feedback. Examples over the last year include:

    - Prince Charles Hospital/Outpatients – A patient, who is a main carer for his disabled son, was often being provided with outpatient appointments for late afternoon, but he was unable to attend due to having to pick his son up from school. Appointments are generated via an electronic system (Myrddin patient administration system) , and due to the involvement of the Patient Support Officers, and alert note was placed on the Myrddin system and in his Medical Records, indicating that he should have morning appointments only.
    - One of the ways in which the Health Board shares learning from concerns is by working with patients and relatives to develop digital accounts of their care. These are known as *patient stories.* Once such account was provided by the mother of a girl with severe learning difficulties who was not sufficiently listened to by staff during her admission to hospital. This story will be used with existing and new staff to deliver training on dignity and communication.
    - As a result of a number of complaints about waiting times in the Accident & Emergency department, the Patient Support Officer has worked closely with the Senior Nurse for the Emergency Care Centre to compile a patient information leaflet and posters, to provide better information and advice for patients on waiting times, assessments, investigations and the running of the department.

- Formal Process

  The Concerns Team manages the Health Board's formal complaints process; all written complaints received are graded for their severity, based on the information contained within the letter of complaint. The person who makes the complaint is then provided with a single point of contact – a member of the Concerns Team who manages their complaint through to a satisfactory conclusion, by working with the Head of Nursing for the relevant Directorate who will lead an

investigation.

Complaints – Activity and Performance

During the year 2012/13 the Health Board received 637 formal complaints, consistent with the 642 formal complaints received in 2011/12. Table 5 shows the numbers of complaints received, by month for 2010/11 and 2011/12.

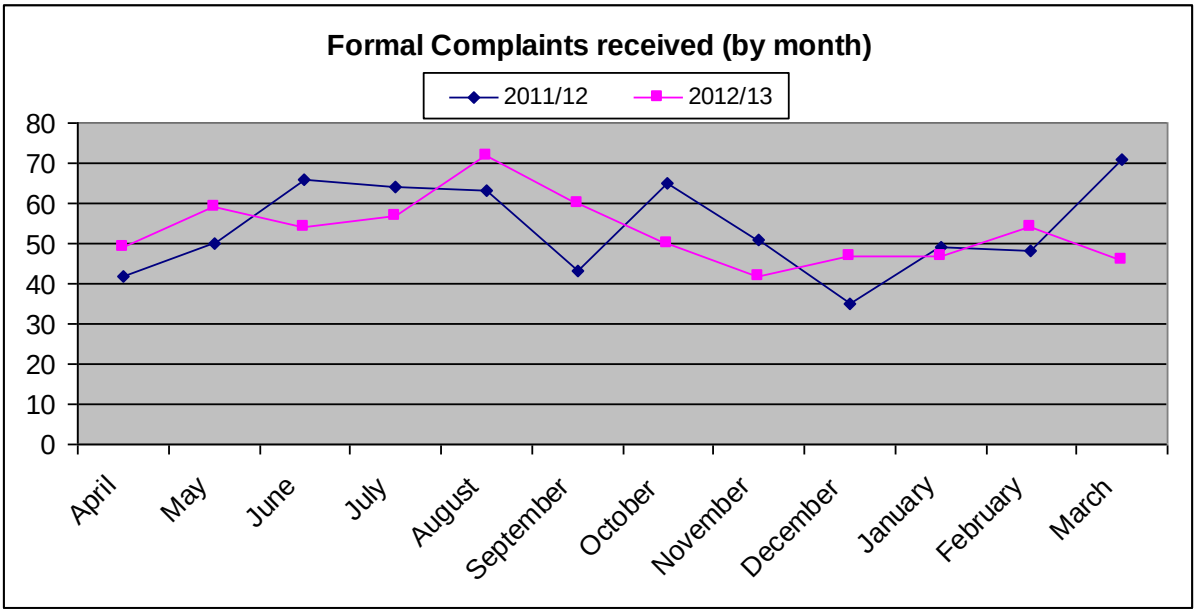


Table 5: Formal Complaints received by month

Patients can make complaints in their own right or can ask a range of people and organisations to deal with the matter on their behalf, with their explicit consent. The position for Cwm Taf Health Board is reflected in Table 6:

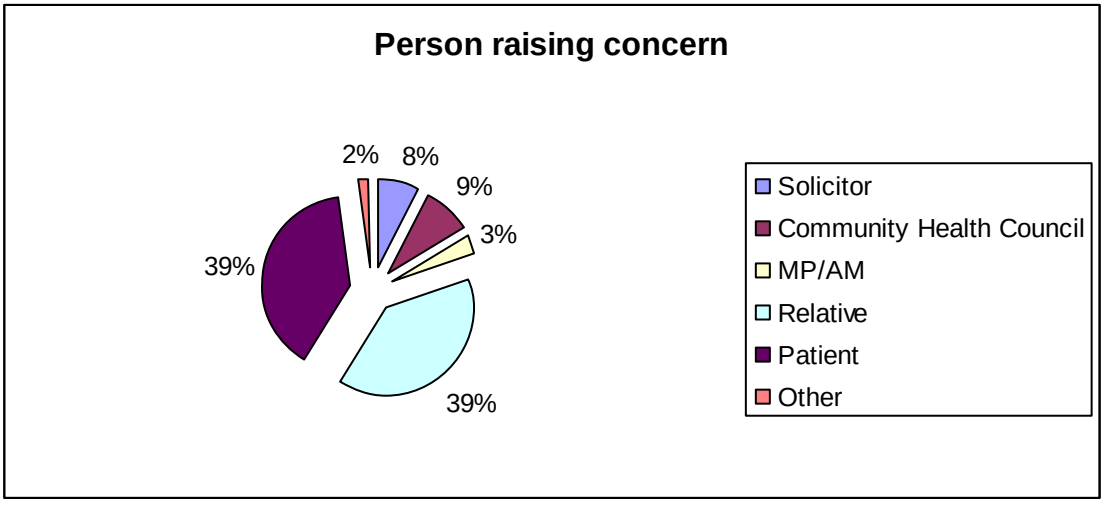


Table 6: Person making the Complaint

Table 7 shows the Health Board department or Directorate) involved in each complaint:

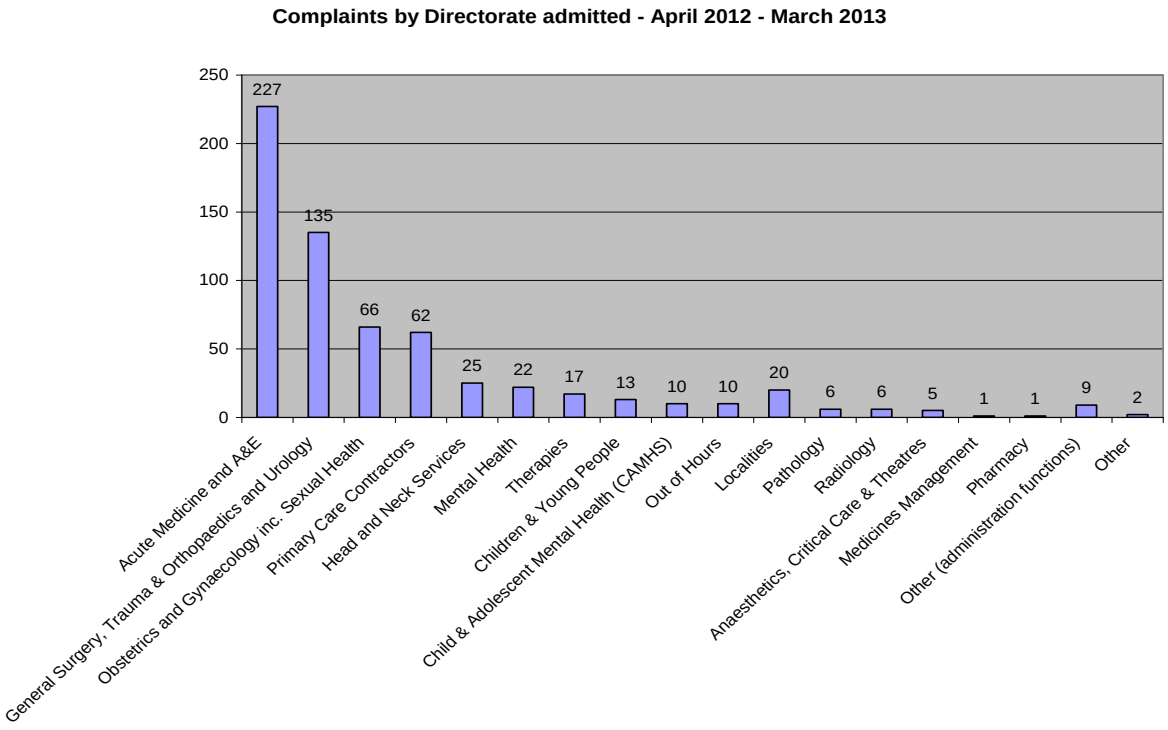


Table 7: Complaint received per Directorate

Many complaints have more than one element of dissatisfaction. However, each complaint tends to have a primary subject and the following graph shows the main subject type:

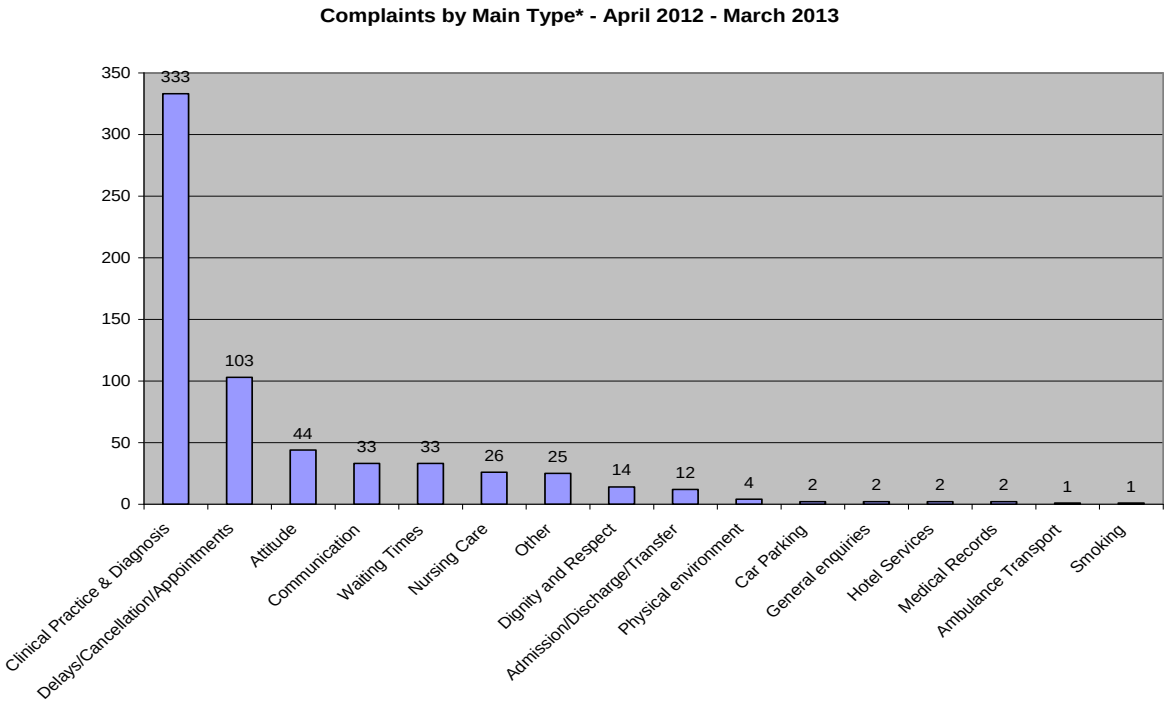


Table 8: Complaints received by primary type

Under *Putting Things Right*, the Health Board is required to respond to complaints within 30 working-days or, if there are reasons why this cannot be achieved, then the person raising their concern should be contacted to explain why the response cannot be given, and advised of an expected timescale for them to receive a substantive reply.

During the year, meeting the target for issuing an interim response to patients or their family, was very challenging for a variety of reasons. The overall response rates are given in the Table 9.

Response within 30 working days Target	Response within 6 months*
39.1%	96.2%

* For first three Quarters of the year.

Table 9: Performance against targets for response to complaints

The Concerns Team works hard with directorates to meet the timescales for responding to complaints. During the year, the processes for keeping patients and their families informed about the progress of an investigation, where the target cannot be met – for example where investigations may be complex, and therefore take longer - significantly improved.

Working together to address patient's concerns.

During the year, the Health Board has used a range of services to assist in resolving complaints. Specifically:

- The Health Board works closely with the Community Health Council (CHC) Advocates in order to resolve complaints to the satisfaction of patients and their families. The Health Board is proactive in signposting the advocacy services that the CHC provides, and is very grateful for the assistance that the advocates give in resolving concerns.
- Independent Expert advice has been sought and provided for two complaints in the year, to assist the person raising the concern to understand the treatment they received.
- In order to deal with Redress cases, the Concerns Team has sought advice from solicitors at Legal & Risk Services Wales, on resolution of complaints and offers of Redress.

<u>Primary Care Complaints</u>

Primary Care Contractors, including GPs, Dentists, Opticians and Community Pharmacies, are responsible for dealing with complaints received about the services that they provide. Many complaints are resolved directly by practices and the Health Board is not asked to get involved. However, some patients and their families write directly to the Health Board and in these circumstances, the Health Board determines

whether or not it is appropriate for the practice to investigate the concern and respond directly to the patient, with a copy of the response being sent to the Health Board for review. Figures for complaints about Primary Care Contractors are included in the figures above, where the person making the complaint wrote directly to the Health Board rather than the Contractor.

Referrals to Second Stage

The Health Board makes every effort to resolve concerns to the satisfaction of patients and/or their family. However, if a patient or their family is not satisfied with the resolution offered by the Health Board, they are able to refer their concerns to the Public Services Ombudsman for Wales who will consider whether to investigate their concerns.

During the year, patients or their families referred 57 cases to the PSOW. The PSOW concluded 56 cases during the year, although due to the timescales for investigation, not all of these cases related to complaints referred within the period. The table below summarises the outcome of cases.

Premature – the PSOW considered that the Health Board had not had an opportunity to resolve the complaint.	16
Case closed by PSOW after initial review – the Ombudsman was content there were no issues to investigate further.	17
Discontinued	4
Quick fix by Health Board	2
Section 16 report (see below)	2
Section 21 report (see below)	10
Complaint not upheld following investigation	5
Total cases concluded by PSOW	**56**

Table 10: Public Services Ombudsman for Wales – concluded complaints

- 'Section 16' report. Section 16 reports contain recommendations and which the Health Board has to publish. This reported related to the care provided to a patient following a fracture and the delay in referring to a specialist centre.
- 6 'Section 21' reports. These are reports where there are recommendations made but which do not have to be published.

Redress

The *NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011* came into force on 1st April 2011. Under these arrangements the Health Board is required to identify those concerns where the investigation finds that harm has been caused because of a breach of duty of care. In these cases, the Health Board is required to

offer redress to the person, which can comprise of:

- a written apology;
- a report on the action that has been taken, or will be taken, to prevent similar concerns arising;
- the giving of an explanation, and
- the offer of financial compensation (up to a value of £25,000) and/or remedial treatment, on the proviso that the person will not seek to pursue the same through further civil proceedings.

Benefits of the process for the Health Board and for patients include a reduction in costs, and a reduction in the time taken to settle cases to the satisfaction of all parties.

During the year the Health Board identified 21 cases where there had been a breach of duty of care which may have resulted in harm. Due to the nature of the redress process, which takes some time to agree a resolution - the people who made these complaints will have received a written response, and the Redress component was ongoing at the end of the year. For this reason, it should be noted that some of the cases identified below relate to complaints received in 2011/12.

The Health Board settled 9 cases opened during 2012/13 and further 14 cases from the previous year. The financial costs of redress cases were as follows:

Cases opened in:	Defence costs	Claimant's Costs	Damages
2011/12	£2,300	£26,302	£44,850
2012/13	£2,340	£3,840	£25,278

Damages for the cases ranged from £250 to £10,000.

Compliments

A total of 4,649 compliments were recorded, which included formal letters/correspondence expressing gratitude, and appreciation for treatment, sent directly to the Chief Executive. Many more cards, letters, and gifts were also sent directly to the clinical teams from grateful patients and relatives, which have not been formally recorded.

In addition, many patients or their families are now choosing to indicate their thanks and gratitude via social media such as Facebook and Twitter.

Clinical Negligence Claims

Alongside the new redress process, the Health Board continues to receive new clinical negligence compensation claims. During the year 137 clinical negligence claims were opened - an increase on the previous year of 42% when 96 were received. This increasing trend is similar to that being seen by other Health Boards in Wales.

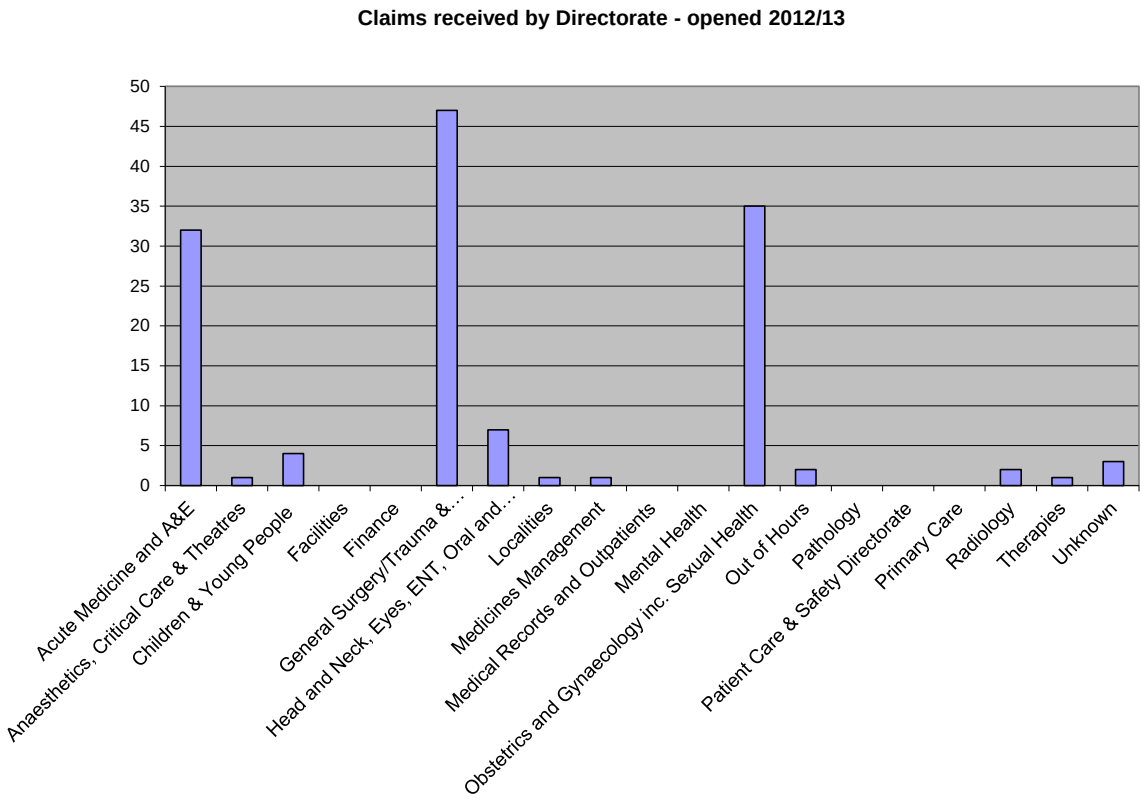


Table 11: New Clinical Negligence Claims received per Directorate

Cwm Taf Health Board understands that where errors have occurred which have caused harm to patients, then it has a legal obligation and duty to provide compensation. However, the Health Board also has a duty to ensure that it justifies the public money it spends on compensation claims, and will therefore defend clinical negligence claims where there is evidence to support a defence. During the year, a total of 52 clinical negligence claims were managed to be successfully defended or withdrawn, with savings - based on an estimate of the value of the claim - of £9,185,000.

The Health Board made payments of £7,536,000 for clinical negligence claims during the year. It should be noted that many of these cases related to cases from many years earlier, and Cwm Taf Health Board continues to deal with cases from the four former health bodies in Cwm Taf. The Health Board's liability is limited to £25,000 for any individual claim - any values greater than this are reimbursed by the Welsh Risk Pool.

- Open Clinical Negligence Claims

  Clinical negligence can take years to conclude, and at the end of 2012-13, there were 327 ongoing clinical negligence claims.

- Settled Claims

  During the year, the Health Board settled 24 clinical negligence claims and, in addition, the Health Board defended 49 clinical negligence claims.

The breakdown of these claims, by directorate, is shown in Table 11.

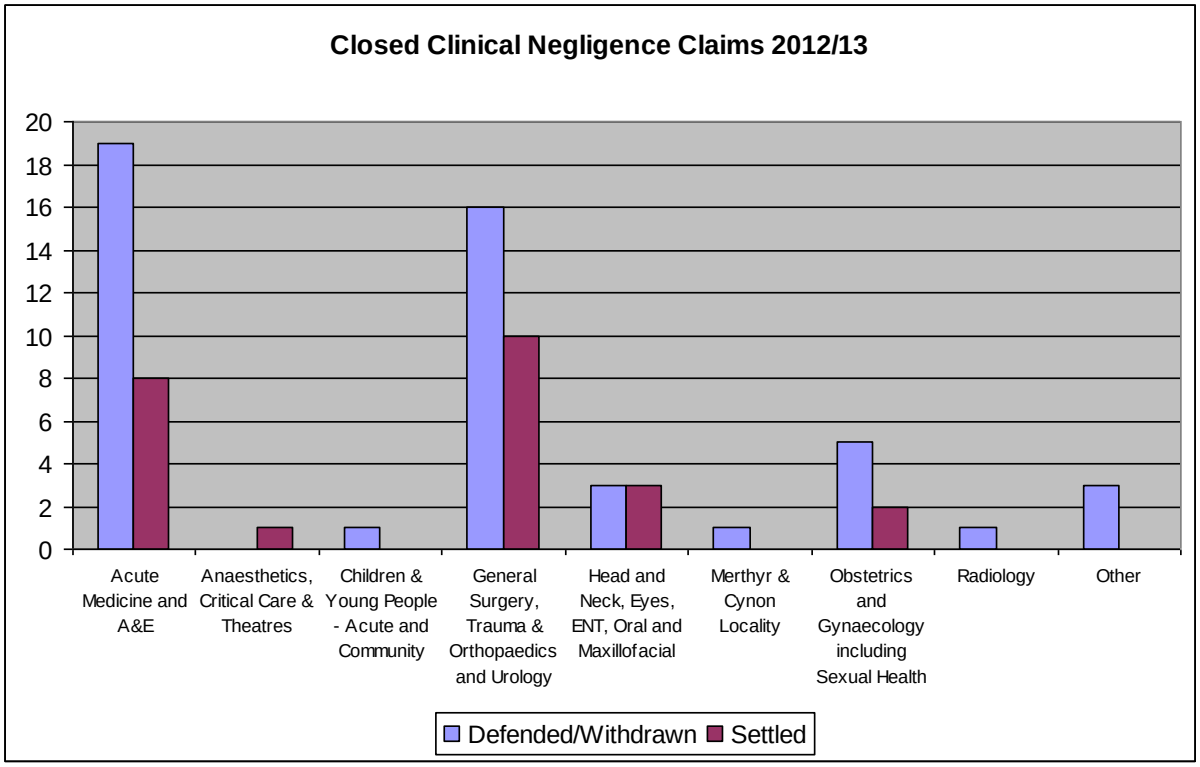


Table 12: Settled and defended Claims per Directorate

Themes, trends and key issues

Significant Achievements

There have been a number of significant positive achievements in dealing with concerns over the year, including:

Feedback from external sources

A solicitor who deals with claimant's cases has recently approached the Health Board to give positive feedback in relation to the way that the redress cases are dealt with. They stated that ' *I think this case has demonstrated that with common sense on both sides, complex matters can be dealt with under Redress. I certainly found some of the issues quite challenging'.*

Corporate support - Concerns Team

The whole Concerns Team is now co-located within Ynysmeurig House which allows closer collaboration between staff managing complaints, claims and patient safety. However, the Patient Safety Improvement Managers work flexibly to cover all areas of the organisation, supporting senior managers and clinical staff to deal effectively with all concerns relating to patient safety.

Information for staff

The Concerns Team has developed a comprehensive intranet site for staff. The site provides information on support available for staff in dealing with concerns, tips and good practice, and useful reference documents.

Patient Safety Alerts

As a result of investigations into patient safety incidents within the Health Board, the Patient Safety Improvement Managers, in conjunction with their clinical colleagues, developed clinical alerts, which were subsequently circulated widely. They are intended to highlight learning from patient safety incidents in order to raise staff awareness and reduce the risks of recurrence, for example:

- Ensuring that medication that has been provided to patients is taken – this follows a trend of incidents where medication, left by staff for patient to take, was being forgotten or lost.

Training

The Concerns Team organised a series of legal seminars, with support from colleagues from the medical education department, aimed at senior staff from multidisciplinary teams. The seminars were delivered by a range of speakers including the Her Majesty's Coroner, a barrister at law, a solicitor from Legal & Risk Services, and senior Health Board clinicians. Each session used real examples of concerns to illustrate best practice and share learning. The theme running through all of these sessions were selected because they were factors in a high number of concerns:

1. Communication
2. Consent
3. Documentation

Newsletter

The Concerns Team developed a 'CLICS Newsletter' (Concerns Leading to Improvements in Care and Services), aimed at all staff. It's based on anonymised case examples of patient safety incidents, complaints, and claims, and uses them to identify learning where things need to improve, as well as sharing best practice where things have gone particularly well. Positive feedback on the content of the newsletter has been received from clinicians.

Policies and Procedures

During the year, the Health Board agreed:

- A new Concerns Policy and Procedure in line with the *Putting Things Right* guidance.
- The Patient Safety Incident Reporting Procedure.

These have been circulated to all departments to guide best practice, and are also accessible for staff via the Health Board's intranet site.

Welsh Risk Pool Assessment – Concerns and Compensation Claims Management

The Health Board has recently undergone the assessment for this year. There are three parts to the process:

a. Claims Management
b. Concerns Management

c. Learning from Events

The scores for this year demonstrate a further significant improvement on those achieved previously. A comprehensive work plan is being developed to ensure that there is a further improvement in 2013/14. The scores for the last three assessments are as follows:

Areas for Assessment	2010-11	2011-12	2012-13
1-13 (Complaints and Redress)	Not measured	80.67%	94.70%
14-23 (Claims)	70%	89.43%	96.96%
24-27 (Learning)	Not measured	60.33%	68.08%
Overall Assessment Score	**70%**	**78%**	**86%**

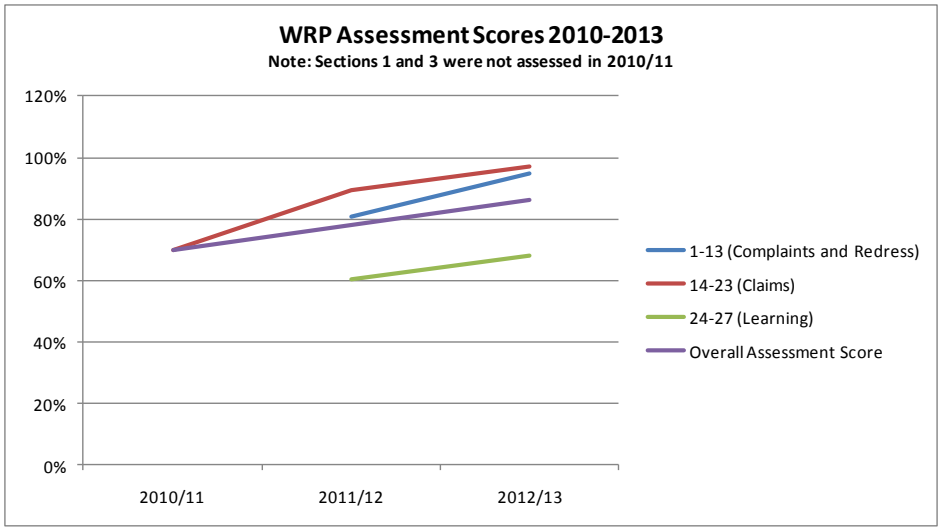


Table 13: WRP Assessment Scores by year

Internal Audit – financial aspects of Claims management

To support the Quality Statement / Statement on Internal Control, the internal auditors have assessed the financial aspect of Claims management by testing of a sample of claims. The audit is undertaken on 25 claims or 25% of all claims - the Audit for Cwm Taf reviewed a sample consisting of 25 claims made against Welsh Risk Pool Services, to ascertain the accuracy of reports, costs, compensation claimed and that any claims / refunds have been dealt with in line with Welsh Risk Pool Services reimbursements. The audit did not identify any risks and concluded that the Health Board has high assurance in relation to claims management processes. Table 12 shows the improvement in assessment scores each year.

Staffing

During the year, a third member of the claims team became a Chartered Legal Executive. The Health Board can therefore be confident that staff specifically working on claims have the appropriate qualifications.

Referrals to Independent Agencies for Investigation

Most people who make complaints to the Health Board are satisfied with the outcome of the investigations, and as part of the implementation of *Putting Things Right*, the Health Board has taken steps to improve the responses to people who make complaints. Evidence of success is reflected by the reduction in complaints progressing to the second stage of the complaints process i.e. to the Public Services Ombudsman for Wales. Last year 35 complaints were referred to the Ombudsman, but there was a reduction in the number accepted for further investigated with 13 not being investigated further.

Learning Lessons and Improving Services

Putting Things Right provides the Health Board with opportunities for learning lessons from claims, complaints, and patient safety incidents. Our aim is that these will lead to sustainable improvements to our services. The following are examples of improvements made as a result of concerns raised by patients or their families during the past year:

- Increased number of nursing staff in the Accident and Emergency Departments to relieve staffing pressures have been following incidents where patients did not receive sufficient pain relief.
- A patient who had been sent a warning letter about their behaviour from their GP practice, raised concerns about the way that the letter was worded. As a result of the complaint, the GP practice reviewed their template letter and shared their learning and improvement with other GP practices in the Health Board.
- An investigation into a complaint where a patient's condition deteriorated while awaiting an appointment with Mental Health Services following referral, revealed the need for GPs to be better informed of current waiting times for routine referrals. This would enable GPs to help manage patient expectations and also consider whether a more urgent referral is required.
- A patient who telephoned the Out of Hours Primary Care Service for advice, did not receive a call back from a doctor or an appointment in line with agreed protocols. The investigation concluded that the system had failed due to shift changeover. As a result, the protocols for handover between shifts have been revised and shared with all staff.
- As a result of a trend in concerns relating to inadequate communication by staff with relatives. In some cases this contributed to sub optimal care. The learning from these examples is now used in staff training to highlight the importance of listening to family members and close friends of patients, and recording this in patient records, in recognition that the information can be critical to providing the best care. an important part of their care.
- A patient experienced a delay in diagnosis of right quadriceps detachment – this delay adversely affected the success of their

surgery. The professional practice of the Consultant Orthopaedic Surgeon has changed as a result:

  - patellar injuries are now x-rayed or scanned prior to further treatment;
  - Computerised Tomography scans are undertaken on all patients who present, prior to arthroscopic procedure;
  - an audit has been undertaken to help identify risks and drive further improvements.

- The Health Board works hard to minimise patient falls in hospital – an important part of prevention is correct assessment of the patient needs and risks. However, despite a good assessment and monitoring, it is sometimes impossible to prevent a fall. As a result, the Health Board has invested significant money in low level beds which are available for use where the risk of a fall is assessed to be high.

Shared learning. The learning from concerns is shared both internally, and more widely with other organisations whenever appropriate, so that as many as possible can benefit, and so that this contributes to our commitment and drive towards continuous improvement. Whenever possible, anonymised examples from concerns are used to support staff training events.

Next Steps - priorities for improvement

Further work is being undertaken to improve the standards of services and care provided across Cwm Taf Health Board. The concerns process contributes to this by using patient safety incidents, legal claims, and complaints to enable learning and positive change, thus contributing to continuous quality improvement.

<u>The Francis Report</u>

In February 2013, Robert Francis QC published his second report on the care provided to patients at Mid Staffordshire NHS Foundation Trust. One of his recommendations was that "All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work" A number of the recommendations in the Francis Report have direct relevance to the management concerns. Therefore, in order to maximise the learning from the events at Mid Staffordshire NHS Foundation Trust, the Health Board's processes and approach to the management of concerns was formally reviewed against the relevant recommendations.

The review noted that many of the recommendations within the Francis Report are consistent with *Putting Things Right* guidance which the Health Board has been implementing since they were introduced in April 2011. Action had therefore already been taken to address many of the principles

and practice highlighted in the Francis report's recommendations. The review also identified areas which need further improvement - weaknesses and gaps are now being addressed so that the best quality patient care is delivered as safely and compassionately as possible.

Next year, there will be a particular focus on:

- Improvements to concerns training for staff at all levels – this will include learning the valuable lessons gleaned from reporting and thorough investigation of patient safety incidents, complaints and claims.
- Continued publication of the CLICS Newsletter to share learning, promote best practice and highlight changes that have resulted from concerns with the aim of continuous improvement.
- Ensuring that any lessons identified as a result of concerns are implemented and embedded to enhance safety and improve the patient experience.
- Further improvements for systems and processes to embed learning from concerns into service provision and clinical practice, which would be demonstrated via an increased Welsh Risk Pool Assessment score in Section 3 '*Learning'* of the assessment tool.

Conclusion

During the year, the Health Board has embedded processes that were developed as a result of the *Putting Things Right* guidance and has received positive feedback in relation to how concerns are managed.

This year has been one of consolidation and the future promises to provide further opportunities to learn from concerns, consistent with the principles of *Putting Things Right*, to improve the service provided to patients and their families.

For the future, the Health Board will continue to ensure that concerns are dealt with to identify lessons from concerns to make improvements to enhance the patient experience, along with ensuring that services are provided as safely as possible.

Bi-monthly Staff Newsletter

January 2014

Standard Operating Procedure to Reduce SSI's

A draft of this guidance is awaiting approval; the following care is advised:

Women to shower or have a bath using soap on the day of surgery. Particular attention should be paid to axillae, groins, perineum and skin folds

Advise the woman to undress and change in to a gown as close to the operation as possible and when wearing a theatre gown to also wear a warm dressing gown and slippers.

Maintain body temperature above 36°C in the peri-operative period.

Prepare the skin at the surgical site immediately before incision using povidone-iodine or chlorhexidine and allow to air dry

Prophylactic intravenous antibiotics to be given at C Section and no longer than 60 minutes before skin incision.

A glucose level of <11mmol/l should be maintained in diabetic patients.

The wound should be covered with a leukomed wound dressing .The dressing should be removed 24 hours after the c section using an aseptic technique

All women should receive the leaflet "OG03 CAESARIAN SECTION" in antenatal clinic at the time of booking the CS.
All women should also receive the leaflet "CARING FOR YOUR CAESARIAN SECTION WOUND AT HOME" prior to transfer home.

All suspected SSI's to be referred by the GP/ Community Midwife to the Maternity Day Assessment Units for verification and treatment plans

[redacted]

[redacted]

[redacted]

[redacted] Nov 2013

The number of women who described their overall care as good or very good was 85%

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf
University Health Board

Your ref/eich cyf:
Our ref/ein cyf:
Date/Dyddiad:
Tel/ffôn:
Fax/ffacs:
Email/ebost:
Dept/adran:

[redacted]

Dear Nesta

Re: "Using the Gift of Complaints"

Please find attached the information you have requested on behalf of Helen Birtwhistle, to describe the immediate response by Cwm Taf University Health Board to the report published by Keith Evan "Using the Gift of Complaints."

1. **The information requested by David Rees AM: for further evidence from all LHBs/ Trusts in Wales around complaints numbers relating to GPs/ primary care.**

During quarter 1 (April – June 2014) 8 of the 193 complaints received related to Primary Care. All 8 related to care provided by GP practices and none were received for Independent Dental Practices). This is almost half of the number received during the previous quarter when 15 cases were received for primary care.

2. **Examples of good practice already occurring within your LHB/ Trust around complaints**

From 1st April 2014 complaints received have been reported differently:

- All complaints received and responded to **over 24** hours will be recorded as **Local Resolution**.
- All complaints received and responded to **within 24** hours will be recorded as "**On the Spot**".

Contd/…

This change, whilst likely to show a significant increase in the numbers of complaints reported, will maximise the opportunity for early resolution wherever possible. This is also consistent with the new approach which the Health Board is now implementing – that of assessment and triage on receipt, to agree the best approach and to manage complaints wherever possible via direct contact with patients or their families who are raising the concerns.

Changes to Cwm Taf University Health Board Concerns Process since 1ST July 2014:

Following receipt of the Keith Evans' report - 'Using the Gift of Complaints', Cwm Taf University Health Board changed the way concerns (complaints) are handled to reflect some of the recommendations made in the report.

All complaints continue to be graded upon receipt by a senior member of the Concerns Team. Less serious/less complex complaints i.e. Grades 1 & 2 that can be turned around within a 24 hour period continue to be dealt with by the Patient Support Officers who are based on acute sites. These cases are now recorded on Datix as 'On The Spot'.

Grade 1 & 2 complaints that can be dealt with quickly at source but will take longer than 24 hours are now recorded as 'Local Resolution' and a Quick Fix approach is adopted:

- Logged by Concerns Team and passed to appropriate senior person in department/directorate.
- Concerns Team make contact complainant to advise of handler details.
- Handler investigates quickly and contacts the complainant directly.
- Handler writes to the complainant with a précis of outcome/discussions. A copy of the letter to Concerns Team to close the case.
- Quick Fix approach – preferably no longer than one week turnaround – aim for 24 hours.

Grades 3 & 4 complaints will require a full investigation, and are logged by the Concerns Team as 'Local Resolution' although in many cases, a more streamlined approach will be taken in an attempt to avoid repetition of work at Directorate/Departmental level:

- Logged by Concerns Team and in most cases the complainant is contacted directly by telephone to decide (a) if a meeting is preferred– to be held within 30 working days, or (b) whether a formal letter required.
- If the complainant chooses to receive a written response, the usual process will be followed.
- If a meeting is required, this will be organised by the lead Investigating Officer.
- All staff involved will be provided with a copy of the letter in advance so they will be prepared to answer the issues raised during the meeting.

- Notes of the meeting will be forwarded to the complainant with a covering standard letter. This will be deemed to be the 'final response'.
- Further issues arising at the meeting will continue to be dealt with by the directorate and correspondence copied to the Concerns Team.
- Concerns Team should be copied into all correspondence.

It is anticipated that the above changes will provide enhanced resolution as the Quick Fix approach will improve the organisations overall response in relation to timeliness for the complainant and reduce the time taken for staff involved in investigating the concerns.

This is an iterative process which will be closely monitored over the coming months.

In addition, a multidisciplinary review of the complaints process (process mapping) has been undertaken in July 2014 to provide a more patient focused approach that puts the complainant at the heart of processes and to ensure a timely resolution is provided following an investigation that is appropriate to the level of the concern where required. Changes to the process are being implemented with multidisciplinary team members and it is aimed that improvements in performance will be reflected during 2014/15.

Other examples of good practice include:

- Obstetrics and Gynaecology Directorate – using a proactive approach to concerns raised by women attending services. Midwives make contact with women who have raised concerns and arrangements are made to visit each patient at home at a suitable time to discuss their concerns face to face. This has generated an improved resolution to concerns and the attached news letter is an example of this good practice.

- As part of the CTUHB Quality Delivery plan we are promoting care rounding for patients and visitor rounding to improve our proactive communication with visitors and family members. This involves staff being available at visiting times and proactively engaging with family members.

3. The key challenges for Cwm Taf University Health Board.

Risks - Compliance with the 30-day target

Meeting compliance with the 30 working-day target for issuing an interim response to patients or their family continues to be very challenging within the current climate, for reasons of complexity for grade 3 and 4 complaints.

The Directorates/Localities and corporate team work collaboratively to respond to Complaints in a timely manner and there are currently 161 open Complaints, a decrease of 9 since the last report.

Whilst it should be noted that all areas remain under pressure in dealing with the demands of the increased number and complexity of complaints, focused work has been undertaken between the Corporate Team and the Directorates to address the backlog of complaints which resulted in 162 cases being closed during Quarter 4 (70 complaints are closed on average during a 3 month period).

Putting Things Right generated a significant increase in complaints received across NHS Wales, with no additional resources. The concerns team continue to review processes to improve efficiencies and outcomes for complainants.

4. The total number of complaints received and the proportion of which relate to primary and to secondary care.

The Health Board received 193 complaints during Quarter 1 (Apr-June 2014) an increase from the 153 received in Quarter 3. This equates to an increase of 26%. The main reason for this increase is due to the change in the way complaints are reported as explained in point 2 above. Of the 193 received, 8 related to Primary Care (4%). This is a significant decrease on the previous quarter when almost 10% of the 153 complaints received related to Primary Care.

I have attached Cwm Taf UHB Annual Concerns report 2012/13), as the 2013/4 is just being finalised.

The Health Board received 591 formal complaints between 1st April 2013 and 1st April 2014. The complaints received were within the main categories:

Category	Number
Admission/Discharge/Transfer	25
Attitude	40
Communication	55
Clinical Practice & Diagnosis	287
Delays/Cancellation/Appointments	100
Dignity and Respect	6
Delays	6
General enquiries	2
Health Records	1
Hotel Services	1
Medication - Administration	1
Nursing Care	28
Other	15
Unexpected Complications	1
Unexpected or Trauma Related Death	1
Waiting Times	21

I hope that I have been able to provide you with the information that you require. If you need any further details please do not hesitate to contact me.

Yours sincerely

Mrs Allison Williams
Chief Executive/Prif Weithredydd

Cwm Taf University Health Board

Over the last 6 months we have reviewed the complaints process both internally to the Corporate team and with the Directorates. A number of process mapping exercises have taken place and changes have taken place.

Whilst it was happening in some cases, as of the 1st July we are now triaging all complaints to determine how they can most appropriately be dealt with which involves all complainants where appropriate receiving a telephone call from a member of the concerns team to agree how they would like to take their complaint forward (options are provided). This will prevent complaints unnecessarily going through the formal complaints process providing the complainant with the best outcome in an appropriate timescale. This will also assist in ensuring that those where a formal RCA investigation is required can be undertaken efficiently.

In addition as part of the support to the Directorates the Complaints officers are spending time within the Directorates with Consultants, Senior Nurses etc to draft responses and address delays in the process. Directorates are finding this of great benefit and it has enabled us to address the backlog of outstanding complaints. This is in addition to the Patient Support Service who continue to assist within concerns within the service.

There are also examples of good practice within the Directorates:

- Within midwifery contact is made with all women to address concerns, a meeting is offered and issues are addressed at source
- At YCC a welcome pack is provided which includes a letter from Ceri Wilson introducing herself and advising of how to raise any concerns patients/relatives may have.

Hywel Dda Health Board – Putting Things Right – Keith Evans' Report
Number of Concerns received during 2013/14

For the period 1st April 2013 to 31st March 2014 **841** formal concerns were received. 71 of these complaints were primary care related (42 general practice, 1 pharmacy, 0 opticians and 28 dental, including access to orthodontic services).

In relation to good practice in line with the recommendations of Mr Keith Evans' report the Health Board has enacted the following in response to the key themes:

Patient Support and early resolution of issues

The Health Board introduced a Patient Support and Advisory Service in 2010.

The role of the PSAS is to:

- Provide a service which offers a speedy resolution to concerns, as an alternative to raising a formal concern;
- Provide a service that is easily accessible and responsive to the needs of patients, their carers, family and friends;
- Act independently, addressing any concerns at the point of origin, helping to resolve patients concerns quickly and improve the outcome of care in the process;
- Provide confidential advice and support to patients, their families and friends;
- Provide accurate and timely information on local health services; and
- Support staff at all levels within the organisation to develop an open and responsive culture.

The introduction of the Patient Support and Advisory Service has been very positive. The number of queries and concerns dealt with by the service has increased each year. During the past financial year, the service received 908 concerns, with only 17 of these needing to be passed to the formal concerns process. The Health Board will continue to develop this service and continue to raise awareness amongst staff and members of the public.

The Health Board is pleased to see a continuing reduction in the number of formal complaints being received. Since the introduction of the Health Board in 2009, the number of formal complaints has reduced by 35%. In relation to the number of serious concerns received, this has reduced by 40% in the last 3 years.

Accessing information and support is a consistent theme throughout Mr Evans' report and the Health Board will ensure that the PSAS teams are working closely with staff on wards and other clinical areas to ensure issues are resolved as and when they arise. This service ensures that patients and their families receive early resolution to concerns without having to utilise the formal process and it supports the delivery of improved clinical care.

Accessibility

All concerns are received into one single point of access (the concerns hub), which is accessible by freepost, low cost concerns telephone number; e-mail and texting. The hub processes the concern according to the grading and nature of the concern and will ensure that any safeguarding issues are escalated upon receipt. The patient support facilitators are all based in the acute hospital settings and accommodation changes are being made to ensure these staff are located near to the entrance/reception areas on each site. Branding of the service is currently being reviewed by the concerns team. Visibility and identification of patient support staff is top of the agenda.

Independence in the Investigation Process

A serious concern case review group has been established weekly, with senior managerial and clinical representation. The Group will review each new serious concern (grade 3 and above),

agree an investigation officer from a central database of trained investigators and agree the terms of reference and approach to the investigation. The progress of the investigation and communication with the patient/complainant will be reviewed regularly by this group to avoid any unnecessary delays in the process. This Group will also decide on whether an independent investigator or external clinical report is required from the outset particularly where serious allegations of neglect and harm are raised.

Patient Experience and Customer Feedback

The Health Board recognises the importance of customer/patient feedback and will be utilising on-line surveys as one of the ways to achieve this. The Health Board is registering with the patient opinion website which will capture views on a wide range of health care issues. We will also utilise current patient engagement mechanisms, such as focus groups to capture views on the concerns handling within the Health Board.

Hywel Dda University Health Board

Hywel Dda University Health Board aims to ensure greater openness and transparency, whilst respecting confidentiality, across the organisation. As part of the University Health Board's work on organisational culture, there was a need to promote policies and procedures for staff to raise a concern in a more positive way and to enable staff to feel more comfortable in raising a concern.

Whilst the University Health Board currently has systems in place to raise a concern, the badging of the policies and procedures as 'whistleblowing' can have negative connotations on the individual who wishes to raise a concern

See Something, Say Something' was introduced to make it easier, and more acceptable, for concerns to be raised bu positively encouraging staff to do so.

The 'See Something…Say Something!' logo adds visual impact to this initiative.

COMMUNICATIONS OBJECTIVES

- To raise awareness of the new scheme
- To promote the University Health Board's policies/procedures on raising a concern in a more positive way
- To enable staff to feel more comfortable in raising a concern
- To increase the number of hits to the dedicated Intranet page and the relevant policies
- To monitor (with Workforce & OD) the increase in concerns being raised by staff

Powys Teaching Health Board – Putting Things Right – Keith Evans' Report

Total number of complaints received

151 (which includes those investigated and responded to by Powys tHB) - Of those 30 related to Primary Care Services (26 GPs, 2 Dental, 2 OOH). Under PTR complainants are encouraged to approach a Primary care provider directly and we have not yet received confirmation from all providers of the number of complaints received directly by them.

Good Practice:

1. Health Board applies PTR as flexibly as possible to ensure we provide the outcome required by the person raising a concern
2. We provide a PALS service
3. We facilitate a complaint across services if it includes an element of Powys provider services (e.g. an issue in one of our hospitals, a DGH and a GPP – we investigate our part, ask the practice and DGH to investigate their areas and then Powys tHB provides an overall responses to all issues raised which provides a more streamlined service and avoids complainant approaching multiple organisations)
4. We have good relationships with CHC staff and meet on a regular basis to maintain good flow of communication
5. Good relationship with GP Practice Managers who regularly contact the Concerns team for advice when handling complaints

Challenges:

1. Lack of resource as the central teams remit has broadened over recent times
2. Due to low number of cases being considered for redress, it is challenging for redress panel members to make comparisons when making decisions on quantum. This also impacts on the skills required to make such decisions.

Velindre NHS Trust - learning from serious incidents

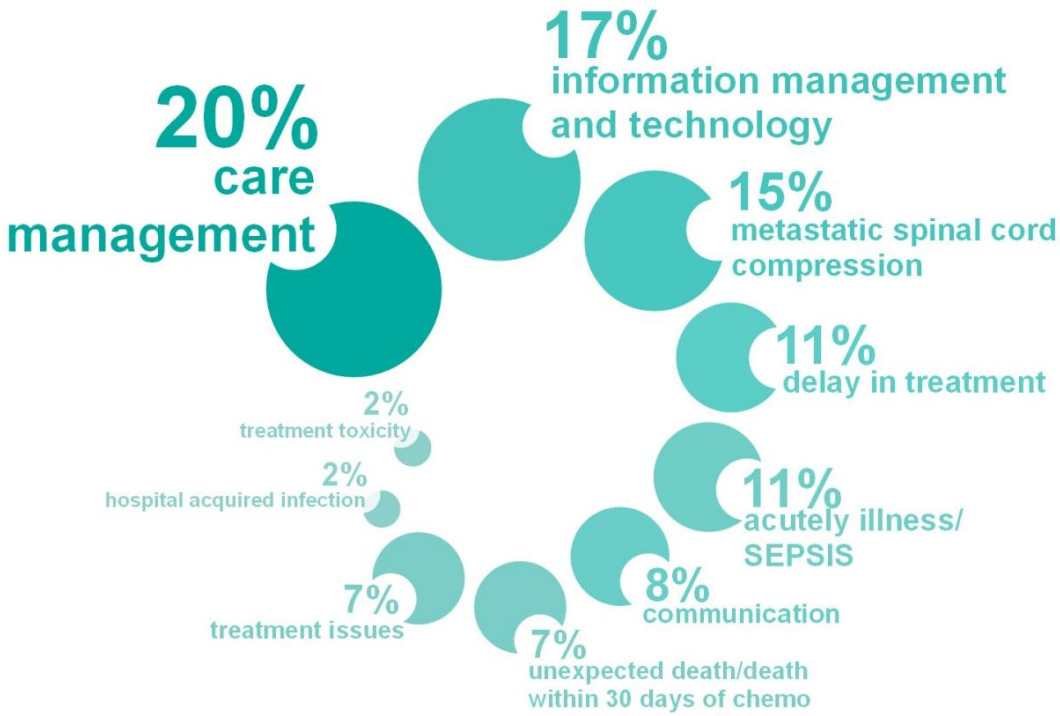
Velindre Cancer Centre's 'Significant Clinical Incident Forum' (SCIF) investigates clinical incidents and aims to:

- improve care and services provided;
- encourage openness and transparency;
- identify areas of learning; and
- make changes in practice when appropriate.

For each clinical incident reviewed, the Forum tries to identify the 'root cause' of whatever went wrong. After each meeting key areas of learning are sent out to all clinical staff and every three months an open learning event is held for staff, patients and carers.
The multi-professional nature of the SCIF team enables it to work with all staff groups at the Cancer Centre.

The SCIF has been invaluable in promoting clinical engagement and has brought clear benefits in patient care and outcomes.

The below graphic shows the type of concerns investigated by the Significant Clinical Incident Forum during 2013:



TO: Welsh NHS Confederation

FROM: Mick Giannasi Chairman

DATE: July 2014

SUBJECT: WELSH AMBULANCE SERVICES NHS TRUST RESPONSE TO KEITH EVANS REPORT

Areas of good practice

- Concerns Monitoring Group is chaired monthly by the CEO. This is the Trust's escalation platform where all open concerns are reviewed and specific cases will be highlighted for discussion
- Live Concerns dashboards have been developed for each Heads of Service based in each Health Board area
- Monthly reporting on concerns and accolades is provided to the Quality Delivery Committee and subsequently the Trust Board. Quarterly reporting is provided to the Ombudsman and annually to WG
- The Trust has appointed a Non Executive Director as a Concerns champion
- Patient Stories are presented at the start of each Trust Board to ensure the patient is the focus of the meeting
- The Trust has implemented a single point of contact for complainants/patients where concerns can be answered through a central email address, a national 0300 number or our PTR website; here complainants can be directed to Trust Managers if required. All letter/emails/telephones messages are registered and acknowledged centrally
- A comprehensive quality assurance process has been successfully implemented across the Trust culminating in all resolution letters reviewed by the relevant Head of Service and finally reviewed and signed by the CEO
- The Trust has introduced the role of an Investigating Supervising Officers (ISO's) who have been assigned to a Health Board area so all complainants have a named contact. The ISO's will make contact with the complainant to discuss the circumstances of their concern and to engage early on to ensure they have a single contact in the Trust and they have the support they require whilst their concern is being investigated
- ISO's maintain regular contact and provide support to patients and families in navigating PTR within the Trust
- The ISOs' have extensive training on PTR and are supported by a senior investigating manager who has a national remit. The Trust has appointed a Head of Service for Concerns
- The Trust promotes advocacy /CHC engagement and ISOs' have direct links with CHC colleagues who often work together to support patients and families during the investigation and will meet the family/patients to discuss the content of any resolution letters that may contain clinical information this ensures the Trust maintains its ethos of openness and transparency
- No resolution letters are issued on a Friday to ensure the central PTR office is open to address any issues patients may have when receiving their resolution letter
- The Trust has introduced standardised investigating reports and templates. The IO report has been developed to reflect the complexity of the investigation to ensure the level of the investigation reflects the severity of the concern.
- Trust standard template letters have been approved by CHC colleagues and readers panels for their content and tone, however the Trust still ensure each letter is personal
- The PiH are provided with a list of closed concerns and from here take a selection of cases and contact complainants to ask about their experience of raising concern with the Trust
- The Trust has implemented an Organisational Learning Policy and has established a National Organisational Group where data and case studies are presented, colleagues from 1000 Lives are members of the group

Key Challenges

- To formally approve the Trust's PTR structure to ensure the staffing establishment reflects the significant amount of administration associated with fully implementing the PTR Regulations
- To maximise the use of Datix further investment should be made to scope out the potential and capabilities of the system
- The Trust often experiences a delay in accessing the patient's medical records. The GP/ Health Board will charge the Trust a fee for providing any medical records. We also incorporate fees in relation to accessing Medical experts
- We continue to struggle with achieving the 30 day target as predominately EMS operational managers undertaking the investigation are response capable
- Due to the nature of the work undertaken by the Trust many of the letters have allegations of harm and are considered by the Redress panel which will causes a delay in achieving the 30 day target

Annex 1

TOTAL NUMBER OF COMPLAINTS RECEIVED

SERVICE AREA	COMPLAINTS (Including 'On The Spot' Concerns)	JOINT COMPLAINTS (With Health Boards)
EMS Control Centres	169	22
PCS Control Centres	115	0
Emergency Services	294	46
Patient Care Services	393	14
NHS Direct Wales	67	1
Other	12	0
TOTAL	**1050**	**83**

SERVICE AREA	COMPLAINTS (Including 'On The Spot' Concerns)	JOINT COMPLAINTS (With Health Boards)
North Wales	285	40
Central and West Wales	223	18
South East Wales	486	23
NHS Direct Wales	56	2