Meeting Date	6th December 2018	**Agenda Item**	4c
Meeting	Quality & Safety Committee		
Report Title	Patient Experience Report		
Report Author	Hazel Lloyd, Head of Patient Experience, Risk & Legal Services		
Report Sponsor	Cathy Dowling, Interim Deputy Director of Nursing & Patient Experience		
Presented by	Gareth Howells, Director of Nursing & Patient Experience		
Freedom of Information	Closed		
Purpose of the Report	This report provides information on Patient Feedback and Experience, what it means and how we are using it to improve the service. Included within this report is the current performance of our Service Delivery Units and learning.		
Key Issues	The key issues to note since the Committee met in August are: • The inpatient discharge feedback rate, in September 2018 was 21.81% against a target of 35%. • The lowest scoring areas for the score of % who would highly recommend the service to Friends & Family using the Friends & Family returns for July - September 2018 is set out on page 3 with the main themes identified from the feedback; • Patient Experience Team Improvement work priorities for 2018/19 is set out on page 5 and includes patient stories and learning from other organisations • During the period 1st July to 30th September 2018, 359 formal complaints were made. Last year for the same time period we received 334 formal complaints that is an increase of 25 formal complaints made this year. The report highlights that the Health Board's performance against the 30 working day target was 80% for the month of		

<table>
<tr><td></td><td colspan="4">August 2018, achieving the 81% target.
• The Health Board is non-compliant with two Patient Safety Solutions, details of which are provided on page 12-13, and sets out the next actions to be taken to progress compliance.
• Arts in Health section on page 15 provides details patient stories.
• The annual Concerns and Claims Report 2017-2018 provides details on the Health Board's performance against the requirements under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 is attached as Appendix 2.</td></tr>
<tr><td rowspan="2">Specific Action Required
(please ✓ one only)</td><td>Information</td><td>Discussion</td><td>Assurance</td><td>Approval</td></tr>
<tr><td></td><td></td><td>✓</td><td>✓</td></tr>
<tr><td>Recommendations</td><td colspan="4">Members are asked to:
• Note the contents of the report.</td></tr>
</table>

1. SITUATION

The Patient Experience Report is attached as ***Appendix 1*** and provides details of the work undertaken from 1st April 2018 – 30th June 2018, and information on key performance indicators.

The annual Concerns and Claims Report 2017-2018 provides details on the Health Board's performance against the requirements under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 is attached as ***Appendix 2***.

2. BACKGROUND

The Patient Experience Report has been developed following feedback from Non-Officer Members.

3. RECOMMENDATION

The Committee is asked to;

- Note the report and the learning and improvement that is being implemented as a consequence of patient experience feedback and learning from events;
- Support the ongoing development of this report and approach on patient experience by providing feedback from the Quality and Safety Committee.
- Note the annual Concerns and Claims Report 2017-2018.

Governance and Assurance					
Link to corporate objectives ***(please ✓)***	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships
		✓			✓

Quality, Safety and Patient Experience
This report sets out performance against patient experience measures and actins being taken to improve the services that we provide.
Financial Implications
No implications for the Committee to note.
Legal Implications (including equality and diversity assessment)
No implications for the Committee to note.
Staffing Implications
No implications for the Committee to note.
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)
No implications for the Board to be notified of.

Report History	Report previously submitted to the August Committee meeting.
Appendices	Appendix 1 – Patient Experience Report April – June 2018 Appendix 2 – Concerns and Claims Annual Report 2017-2018

Appendix 1

Patient Experience Report
July - September 2018

This report provides information on Patient Feedback and Experience, what it means and how we are using it to improve the service. Included within this report is the current performance of The Health Board's Service Delivery Units and learning.

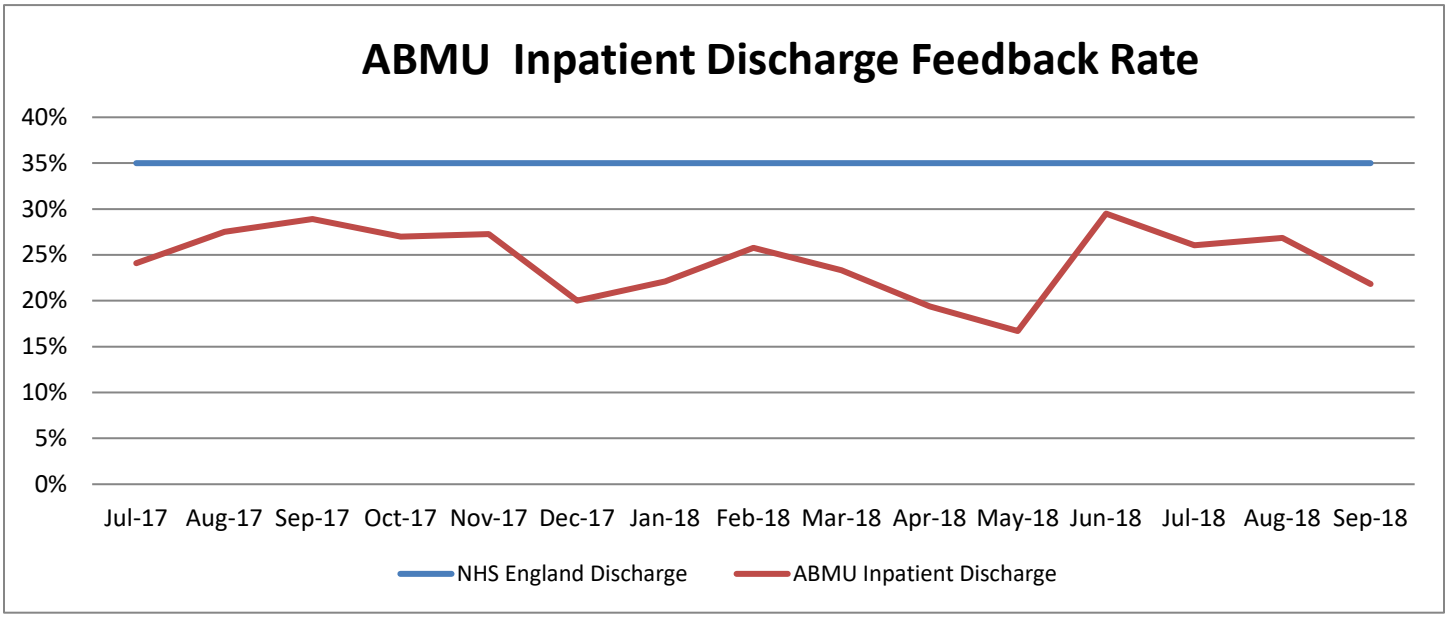
Index

1. PATIENT EXPERIENCE

1.1 Inpatient Discharge Feedback Rates

The Patient Experience Team continues to provide support and guidance to the Service Delivery Units (SDU) on increasing the number of surveys completed.

The graph below indicates the discharge feedback rate benchmarked against the best performing Trusts for patient feedback returns in NHS England (35%). The Health Board's aim is to increase it's rate to 35%, currently 21.81% in September 2018.



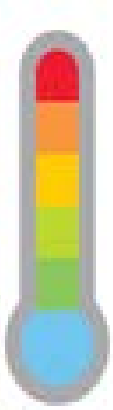
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
NHS England Discharge	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%
ABMU Inpatient Discharge	24.10%	27.50%	28.90%	27.00%	27.28%	20%	22.10%	25.76%	23.32%	19.40%	16.70%	29.50%	26.04%	26.84%	21.81%

1.2 CURRENT POSITION

High scoring areas across the reporting period (all with 100% positive feedback) included:

- Ambulatory Care, Princess of Wales Hospital (12 responses)
- Powys Ward, Morriston Hospital (41 responses)
- Afan Nedd Day Unit, Neath Port Talbot Hospital (101 responses)
- Dermatology, Singleton Hospital (6 responses)

The 10 lowest scoring areas for the reporting period were:



- Corridor 4&5 OPD, Singleton Hospital (57%)
- ENT, Princess of Wales Hospital (60%)
- Neonatal Intensive Care Unit, Singleton Hospital (70%)
- Radiology, Singleton Hospital (71%)
- Clydach Ward, Morriston Hospital (75%)
- Plastic Surgery Outpatients Dept, Morriston Hospital (75%)
- Corridor 7, Singleton Hospital (75%)
- Outpatients - Blue, Neath Port Talbot Hospital (77%)
- Renal Day Unit, Morriston Hospital (78%)
- Fracture Clinic, Princess of Wales Hospital (79%)

The main themes identified in the low scoring areas above were:

- Extreme waiting times and cold waiting room.
- Staff being more caring and not standing around chatting.
- Food not being up to a high standard.
- Car parking on all sites (ongoing issues).

Each of the SDUs receives a monthly detailed report identifying the themes and develops an action plan for improvement at SDU level.

1.3 All Wales Patient Experience Questionnaire

The results below are captured through the Patient Experience Framework questionnaire.

Percentage of patients that ticked 'Always' to the following questions:

Treated with Dignity?

Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
95%	95%	96%	95%	92%	95%	93%	95%	94%	97%	98%	96%	97%	95%	95%

You were given help with feeding & drinking?

Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
79%	82%	73%	85%	85%	86%	77%	91%	80%	88%	53%	77%	89%	67%	81%

Were you given the support you needed to help with any communication needs?

Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
86%	89%	91%	90%	91%	87%	87%	91%	93%	94%	94%	96%	92%	88%	95%

Were things explained to you in a way that you could understand?

Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
83%	85%	89%	87%	86%	88%	88%	93%	89%	90%	94%	91%	92%	88%	90%

Did you feel we did enough to keep you as free as possible from pain?

Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
85%	87%	88%	86%	81%	94%	84%	91%	92%	91%	91%	89%	87%	82%	84%

People are kind and compassionate to you?

Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
86%	91%	91%	88%	93%	94%	88%	91%	91%	96%	96%	90%	87%	88%	92%

People are welcoming, friendly and helpful?

Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
84%	91%	90%	88%	90%	89%	89%	90%	90%	94%	95%	91%	92%	87%	92%

Percentage of patients that ticked 'Never' to the following question:

At any point in your stay did any of our actions make you feel unsafe?

Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
90%	90%	91%	91%	85%	89%	89%	86%	95%	93%	89%	91%	91%	83%	87%

1.4 Key performance Indicators for Patient Experience

The Health Board is now using key performance indicators (KPI's) to demonstrate the Health Board performance against the 4 domains of patient experience.

Real Time – short surveys	Health Board Friends and Family recommendation score for July, August and September has remained the same at 96%. Below are the hospital site scores: Gorseinon Hospital 91%, Maesteg 96%, Morriston Hospital 94%, Neath Port Talbot 98% , Princess of Wales Hospital 96% and Singleton Hospital 96%.
Retrospective – more in-depth surveys	The overall satisfaction score from feedback of the Patient Experience Framework All Wales questionnaire has stayed the same at 87% This is based on the number of people scoring 9 and 10 from a scale of 0 to 10.
Balancing – Concerns, Patient Stories	Chair of the Quality and Safety Committee presented the Patient Story for July to the Board. Title of the story: David and Chris's Story. How improvements to the assessment of care needs for older persons with a cognitive impairment have allowed them to stay in their home. Interim Medical Director presented the Staff story for September to the Board. Titled: Never Event (Future Vision). Staff member shared his experience and learning on the new reflective approach being used to investigate Serious Incidents across ABM.
Proactive/Reactive – texts, social media	365 alerts were received into the Patient Experience inbox for July, August and September combined. ABMU Lets Talk: For the period, July, August and September there were 89 contacts made by members of the public of which 30 converted into complaints for the SDU's.

1.5 Patient Experience Team Improvement Work

An update on work being led by the Patient Experience Team to promote patient feedback is set out below:

- **Using the data wisely:** We collect a lot of feedback and we are working with other ABM teams to ensure we share the feedback. For example, some of our feedback is used to populate ABMs Elderly Dashboard. The Elderly dashboard is an in house system for staff to use. We also recently started to theme the comments/compliments using the Datix system. Again, this work goes on behind the scenes but is vital in improving the patient experience.
- **Patient Stories:** Over the last six months we have worked with the Arts in Health Co-ordinator to write the standard operating procedures and establish digital patient stories as mainstream ABMU practice. In November we will be launching a share point site where staff can access a library of stories to use in meetings and training. They will also be able to access the standard operating procedures, submission form and training applications. It is agreed policy that each

SDU will have two trained story facilitators and a new accredited training course starts in January 2019.

- **Changes ahead:** We have received the newly updated Listening and Learning Framework from the Welsh Government. The new validated questions are to be imbedded in to the patient survey system over the coming months.
- **Workshop 2 with the PALS and PEAS teams: September** 17th, this was the second workshop for the PALS/PEAS staff members and the Governance Managers. Agreed at the workshop was the Service name (PALS), uniforms, draft policy and proposed new job descriptions. Third and final workshop to be planned which will review the Datix system and coding of the complaints.

2. LEARNING FROM FEEDBACK

The Health Board uses feedback from incidents, complaints, Friends and Family questionnaires and systems such as "Lets Talk" and "Care Opinion" to learn following feedback from patients, relatives and staff. Highlights of the learning from feedback is set out in Section 2.3.

2.1 **'Lets Talk'**

The Datix Risk Management system is used to log, store, and track the ABM Lets Talk data/information. This enables the Health Board to use this data when looking at themed reports. For the period, July, August and September there were 89 contacts made by members of the public of which 30 converted into complaints for the SDUs.

2.2 **'Care Opinion'**

ABMU Health Board has subscribed to Care Opinion to be able to respond to feedback/comments made on their website. No comments left during July, August and September 2018.

You Said We Did

YOU SAID	**YOU SAID**
HDU, Singleton: Patient's family complained about the waiting room and how uncomfortable the chairs were. The family stayed for a few days and found it very difficult.	**Neath Port Talbot Hospital**: Issues raised by inpatients concerning boredom on the Wards.
WE DID Unit has now had the go ahead to refurbish waiting area and purchase new chairs	**WE DID** Met with Soroptimist International Port Talbot & of Afante, a Port Talbot ladies choir. Befriending scheme underway and arrangements made for music on the wards and "Pop-Up Cafe's" also on the wards involving tea and chat time for the

	inpatients to assist in alleviating boredom.
You said. Neath Port Talbot Hospital: An outdoor area for patients and family to use. **We did:** Linked in with the carers' service to build joint funding application for works outside. Currently undertaking survey to gain opinions to provide evidence based support for Lottery Bid.	**Ward 10, Princess of Wales Hospital: You said:** Relative told PALS that a patient is having trouble hearing, she usually get drops from her GP how does she go about getting drops in hospital? **We did:** Discussed with patients nurse who told me she would ask the Doctor to have a look at patients ears - information passed to relative – thanked.

2.4 Learning from Events, Patient Experience & Clinical Practice

Princess of Wales Hospital hosted the Learning from Event meeting on 23rd October 2018. During the meeting the Unit shared learning from the never events which occurred in 2017/18 and also from patient experience of care and clinical practice. The learning and changes made included:

- **Action for Pulmonary Fibrosis – Patient Story presented by Clinical Nurse Specialist Respiratory**
  A patient story was played which aimed to raise awareness and support for families with a relative who has pulmonary fibrosis and help improve their physical and emotional wellbeing.
- **Never events –** Incompatible femoral head and femoral stem used, presented by Service Manager.
  - Within the Stryker Implant System for Total Hip Replacement there were three head options on the shelf in NPTH Theatres. Stainless steel heads to be used only on Exeter stems, cobalt chrome and ceramic heads to be used on Exeter or Accolade femoral stems. Two patients were incorrectly implanted with incompatible implants - stainless steel stem onto Accolade stem. Band 6 Team Leader identified the error.
  - Patients contacted and supported and the never events were investigated by the Health Boards SI Team. A reflective practice session was held which provided all staff involved with an opportunity to establish the issues surrounding the incident and as a result produce an Action Plan to improve safety and minimise the chance of recurrence.

- Learning was identified at a local level, delivery level and at corporate level:

  - **Theatre: -** All staff made aware of the incidents. Up-date training for all Orthopaedic Staff. Orthopaedic Team to only put Orthopaedic Implants away to ensure housekeeping in order. White board used in Theatre recording what implant chosen intraoperatively, cross reference checked by circulating practitioner and scrub practitioner, then again with circulating practitioner and operating surgeons before implant opened for use.
  - **Service Delivery Unit: -** All clinicians notified. Stainless steel heads now withdrawn from Theatres. Ongoing work being done standardising kit options for Total Hip Replacements and Total Knee Replacements.
  - **Corporate: -** Standardisation, for two hips and two knee components only in NPTH Theatres.

- **Identifying and Managing Delirium**

  - Common: 20-30% medical admissions
  - Preventable in up to 1/3 cases
  - Early identification and treatment improves prognosis
  - Under recognised & sub-optimally managed
  - Associated with:
    - Increased morbidity
    - Increased mortality
    - Increased length of stay (5-10+ days)
    - Increased risk new care home placement (16% vs 3%)
    - Increased risk future diagnosis dementia

  Unit considered that Delirium was:

  - **Under-recognised -** *Johnson JC, Kerse NM, Gottlieb G et al. J Am Geriatr Soc, 1992.*
  - **Sub-optimally managed -** *Marcantonio ER, Flacker JM, Wright RJ, Resnick NM. J Am Geriatr Soc, 2001.*
  - **Preventable -** *Inouye SK, Bogardus ST Jr, Charpentier PA et al. NEJM, 1999*

The SDU developed a Delirium Assessment Tool to assess patients, guide staff through the investigations required and decide on the treatment options. An awareness campaign will be rolled out across the Health Board to launch the use of the tool.

Never Events – wrong component used/wrong strength lens used

Two never events occurred where one patient received the wrong component and the other patient received the wrong strength lens. Both incidents were investigated by the Serious Incident Team and findings of the report shared with the patients.

The issues contributing to the incidents happening included:

- Multiple pages of documentation with duplication of clinical information can lead to transcribing errors (written on biometry sheet and op list).
- The Biometry printouts include both anterior and posterior chamber lens information.
- Team Brief at the time did not include checking the biometry and this was not covered in a standardised procedure.
- The ophthalmology local procedures at the time were too generic and it was clear a specific LocSSIP was required for cataract surgery.
- Elements of human factors and passive checking processes.

Immediate actions taken included:

- Surgeon, scrub nurse and circulating nurse to ensure WHO timeout is undertaken with patient biometry visible to the surgeon.
- One person (circulating nurse) will write on the white board once verbal communication of the lens and dioptre size is confirmed at the WHO timeout.
- Check with other eye theatres what their standardised checking process is.
- A task and finish group established to review and streamline documentation into a more focussed booklet.
- Development of a specific clinically led LocSSIP for cataract surgery.
- Reflection events held for the two cases to share learning and foster transparency.

Actions taken to reduce recurrence of the incident re occurring included:

- New LocSSIP developed and implemented with a simple but more focussed checking process using the patient's biometry.
- Benchmarked checking processes elsewhere and incorporated learning into the LocSSIP. (Complete.)
- Task and finish group is progressing streamlined documentation.
- Eye Theatre practitioners wanted to learn about biometry and this was added to their PADR objectives. (all have now attended eye clinic to learn about the biometry).
- New process of lens storage introduced and only collecting the correct lens once biometry has been confirmed in WHO timeout.
- Biometry printouts are now streamlined to one sheet. (less is more approach)
- Lens availability decided at team brief and this is now a routine question added to the LocSSIP.

- Action plans and feedback on these incidents to be shared wider to help prevent recurrence.

Never Event – wrong route administration

- Patient was admitted to Ward in March 2018 with abdominal pain.
- Staff Nurse caring for patient went to administer IV Pabrinex and noted that on attending bedside, patient was agitated and required pain relief.
- Staff Nurse left saline flush at patient's bedside and returned to treatment room to draw up Oramorph. Oral syringe was not used and Oramorph was drawn up in an IV syringe.
- Staff Nurse returned to patient's bedside and administered what she thought was IV flush but immediately realised had in fact administered Oramorph via the IV cannula.

Immediate actions taken included:

- Incident was immediately reported and Never Event declared.
- Reflection meeting set up with all members of staff involved and Serious Incident Team to gain an understanding of what had happened and how.
- Round table discussion gave all staff involved a frank and open opportunity to establish the issues surrounding the incident and as a result produce an Action Plan that addressed these and was fit for purpose.

Learning was identified at a local level, delivery level and at corporate level:

- **Ward** –
  - Competencies re administration of medication were revisited, IV and non-IV.
  - Reinforcement of use of oral purple syringes – NPSA Alert resent to all staff.
  - Observational audits to ensure compliance with NPSA Alert 19.

- **Delivery Unit** –
  - Bespoke audit to ensure compliance with contemporaneous record keeping.
  - Documentation also to be addressed in Study days on wards.
  - Report taken to Directorate Board, QPS and A&L.
  - Implementation of HB PGD in POW re use of pre-filled saline flushes.
  - To source multi-use purple bung and gain agreement with Medicines Management Group.

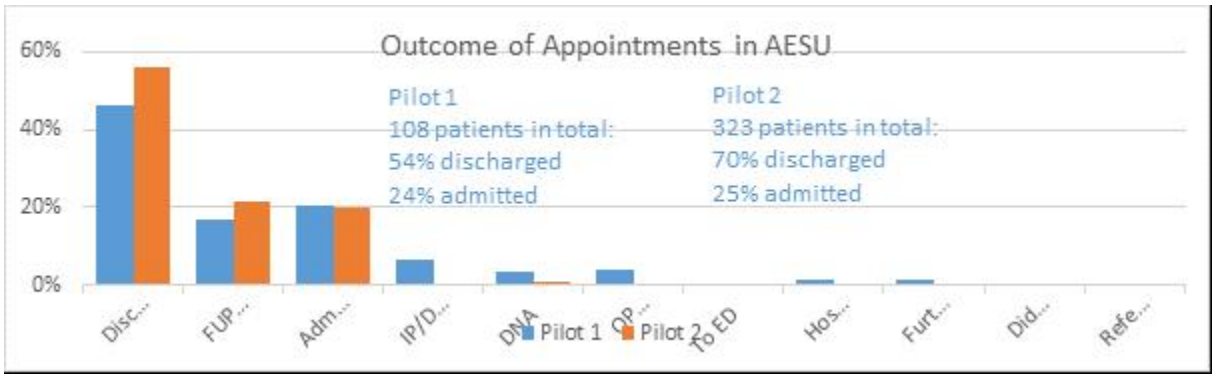
- **Corporate –**
  - Declassification of Oramorph to be reviewed at Medicines Management Group.
  - Consider correct device to support safe administration of solution by enabling the syringes to be correctly attached to Oramorph bottle.
  - Use of pre-filled saline flushes as standard practice across the HB within the PGD.
  - Improve mechanisms for contemporaneous record keeping within Nursing Documentation Review Group.

Ambulatory Emergency Surgery Unit

Two test pilots were undertaken in Princess of Wales Hospital with the aim of making on call fun, efficient, cost less and deliver good medicine. The pilots were carried out between the hours of 8am to 8pm (Weekends = 10 days during the test period patients would have received 'usual care')

In summary, the pilot found that less patients were admitted to hospital during this period.

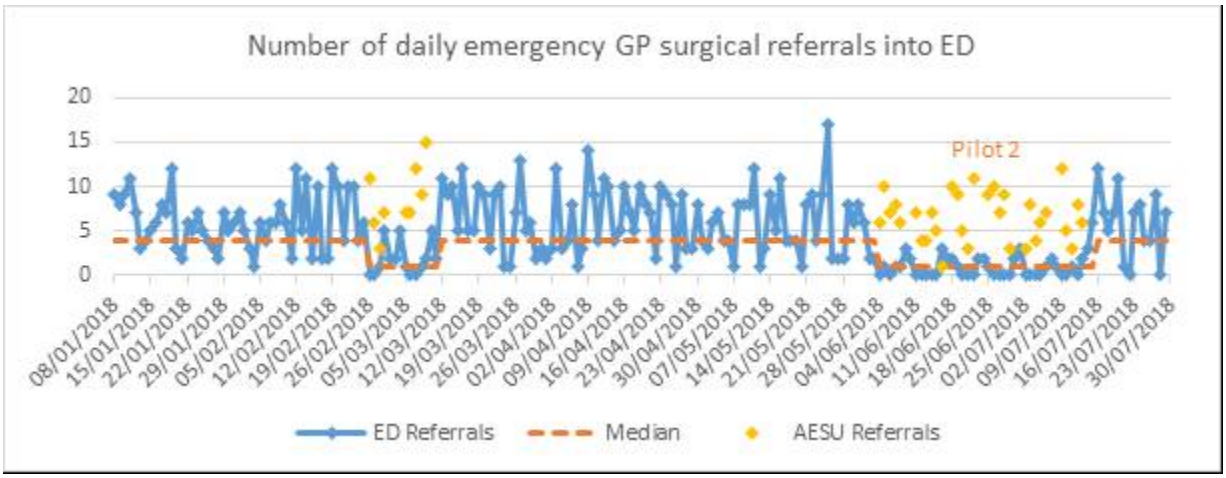
- Presentation: 228 patients presented via the GP – 203 of which entered the AESU process (21 were not required to attend and a further 4 were asked to attend ED directly). 120 patients who self presented at ED also entered the AESU process after triage.
- AESU Process: 323 patients attended an initial assessment/diagnosis with the SDM. 71 requests were made to Radiology for imaging and 76 requests were made to Pathology for bloods. 415 appointments were attended overall, some returned on more than one occasion for follow up (a total of 95 follow up appointments were made).
- Outcome: Of the 323 patients: 227 patients had a final outcome of being discharged without admission, and 81 were admitted.

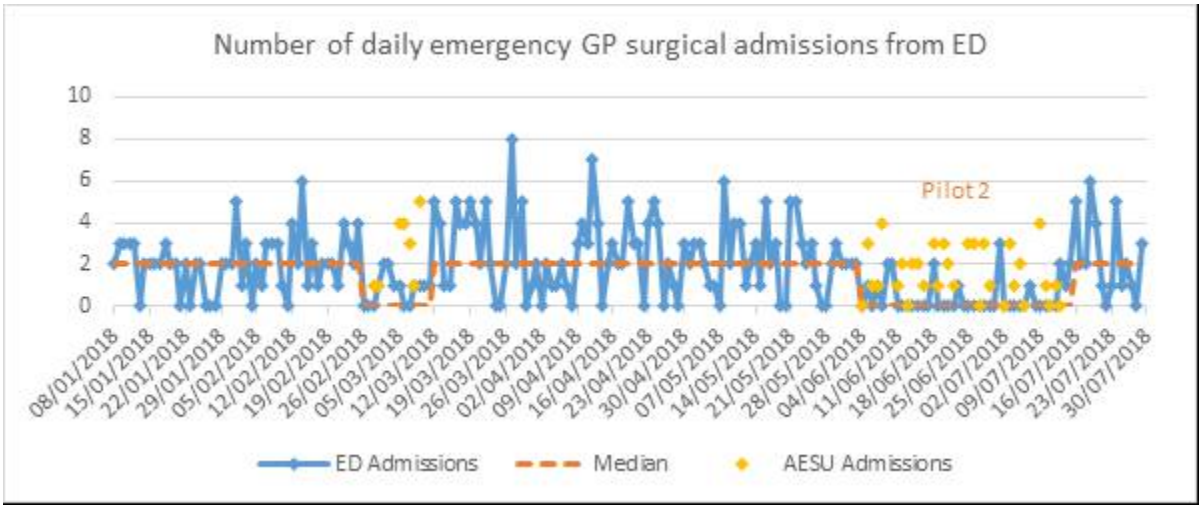


Outcome of AESU attendance

- During pilot 1, out of the 108 patients seen in the AESU, 54% were discharged and 24% admitted.
- During pilot 2, out of the 323 patients seen in the AESU, 70% were discharged and 25% admitted.

Demand & Activity





Patient feedback AESU

Date >= 01/06/2018 and Date <= 20/07/2018

AESU - PoWH

Friends and Family Test Feedback

How likely are you to recommend this ward/unit to Friends and Family if they needed similar care or treatment?

Number of responses	Likely to recommend	Unlikely to recommend	ABMU Rank (position)	Site Rank (position)
35	100%	0%	= 1st /152 wards	= 1st /46 wards

How do we compare within the hospital & Health Board?

The score of 100% compares to a score of 96% for PoWH and 96% for the whole Health Board.

Chole-QuIC – the POW experience

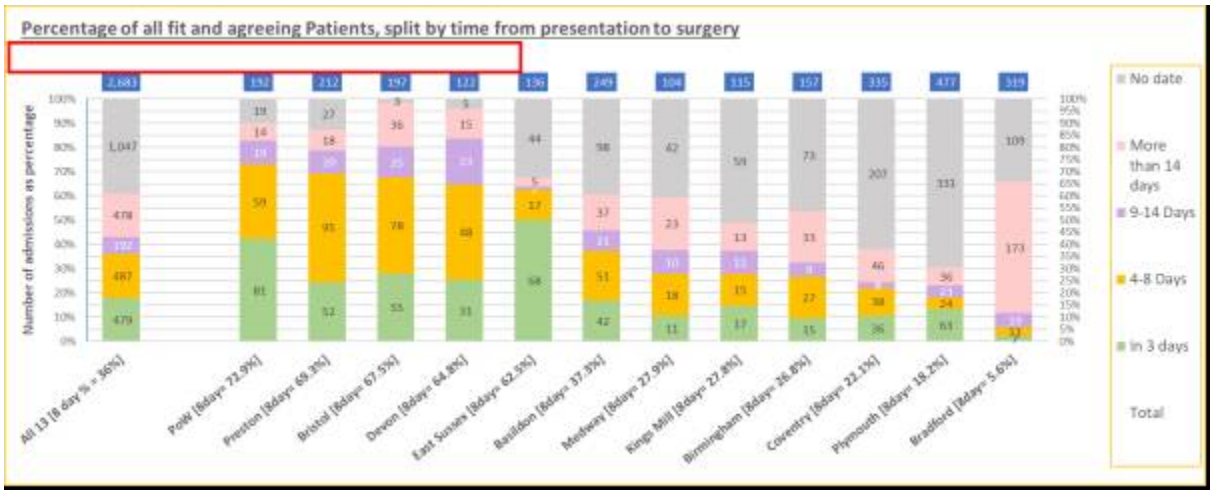
Project carried out with the aim of: 80% of patients having their cholecystectomy within 8 days.

- Acute Biliary disease results in 60,000 hospital admissions
- ~ 1/3 of acute surgical admissions
- 6,000 Emergency LCs (within 14 days of admission)
- 20% readmitted within 8 weeks

Actions taken:

- Engaged patients
- Engaged colleagues (Lana's story)
- Ring-fenced space on two elective lists (SW & BA) per week (to start)
- Anaesthetic assessment
- Rapid PDSA cycles – weekly meeting

Results:



Stratifying:

- Biliary colic – home with date for operation within 8 days
- Acute cholecystitis – surgery on index admission
- Biliary pancreatitis
- Mild – surgery on index admission OR home to return for operation within 8 days
- Moderate – either index admission or within 8-10 days
- Severe – according to clinical need

Next Steps:

- Look at demand for emergency gallbladder surgery ü
- Look at CEPOD capacity ü
- Flexible job plan (SW) ü
- Phase in ERCP patients ü
- Look at <u>overall</u> demand for gallbladder surgery ü
- Integrate with development of AES
- ?Emergency surgeon
- Joined up approach
- Reduction in bed days
- <u>Lessen</u> impact on radiology

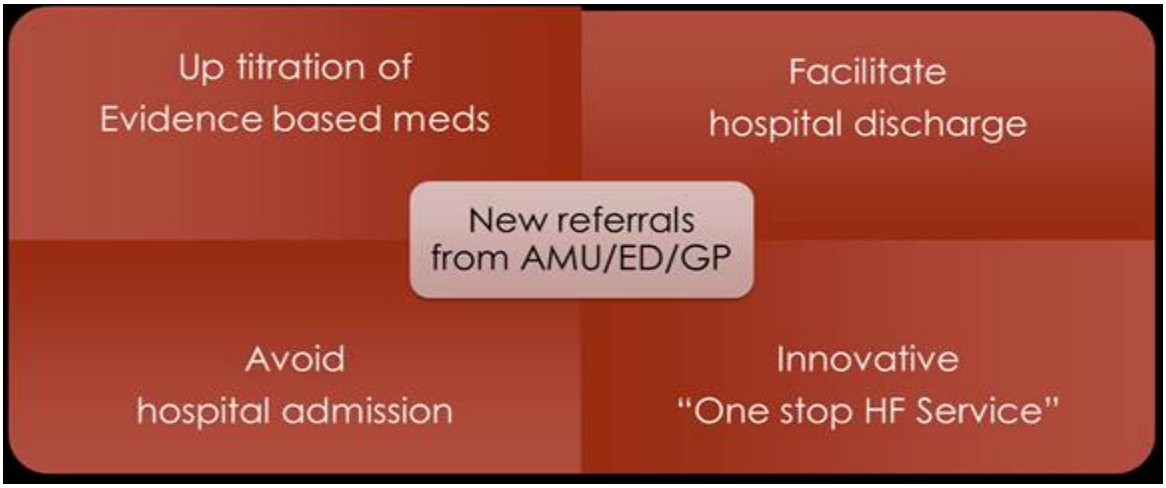
Ambulatory Heart Failure Service

Scale of the problem: 90,000 of patient in UK has Chronic Heart Failure

- 1-2 % of NHS Expenditure
- Increasing number of heart failure cases;

- High readmission rate
- High mortality rate
- Long waits for referral
- 255 of patients die within 1 year.

Ambulatory Heart Failure clinic was set up with the aims of:



During January to September 2018:

- Total Number of patients seen= **399**

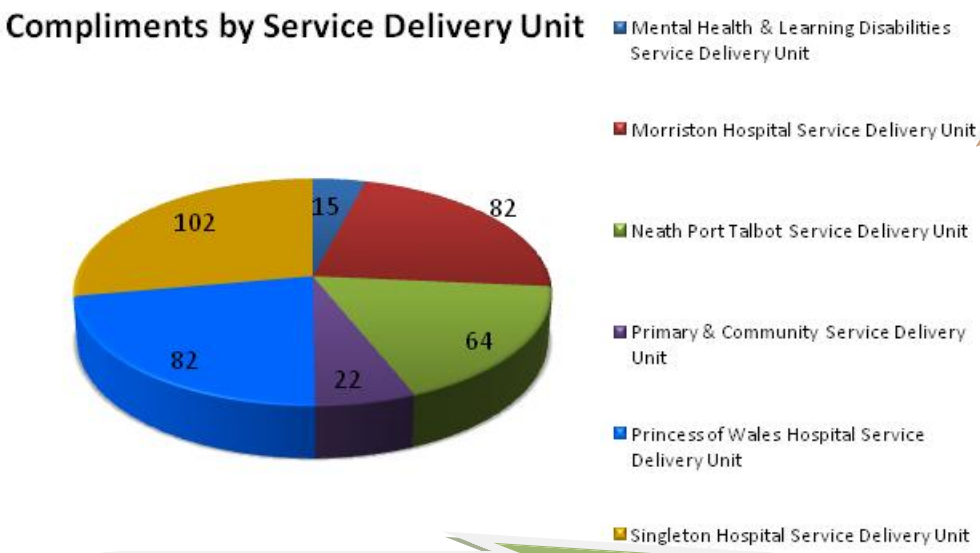
Since Heart Failure Service Nurse in post (May to Sept)

- Total Number seen **152**
- Post discharge 35
- AMU &ED& outlaying wards= 8
- One stop= 6 (Last 2 months)
- IV Iron= 7
- ACT= 2 (admission avoidance and facilitate early discharge)

Next steps

- ❖ Continue to audit activities and measures outcome
- ❖ Number of admissions avoidance
- ❖ Number of facilitated discharge
- ❖ Need to develop service further
- ❖ HF in reach
- ❖ Collaboration with COTE/ACT/ Ambulatory Clinic, etc.

3. Written Compliments July – September 2018



Ward 2, Princess of Wales Hospital
"I wanted to take the time to pass on my fathers and our family's thanks for a truly exceptional level of care that he is receiving in ward 2. My father is a 90 year old patient who unfortunately has had pneumonia and delirium whilst in hospital a normally gentle caring man has turned into someone we don't recognise and has become very agitated and sometimes unknowingly aggressive to staff. Since he was admitted the level of care, empathy, compassion and dignity afforded to both my father and our family has been exemplary.. The staff of ward 3 are always polite and friendly , happy and laughing and nothing is too much trouble for them. I am sure if we paid for private care we wouldn't get any better treatment . We are wholeheartedly thankful for all the staff have done and continue to do for dad".

Ward 9, Singleton Hospital:
"I returned home today having spent 26 days on ward 9, following a holiday illness which led to further complications.
At a time when people are quick to be so negative about the NHS, I feel I have to pass on my impressions.
I have never been treated so well by people who are obviously extremely busy, but still manage to cater for all patients' needs, and all whilst being pleasant and smiling.
It would be wrong to select individuals for praise, so suffice it to say that every single member of staff I encountered was absolutely superb.
This ward should be used as an example of how the NHS should be viewed by the public. Please pass on my most sincere thanks to all concerned".

Community Resource Team:
"Just a few words of gratitude for the care, compassion and reassurance that the team gave to us and our Dad during his recent illness. Sadly, Dad passed away last week but we were so impressed at the professionalism and expertise of your team"

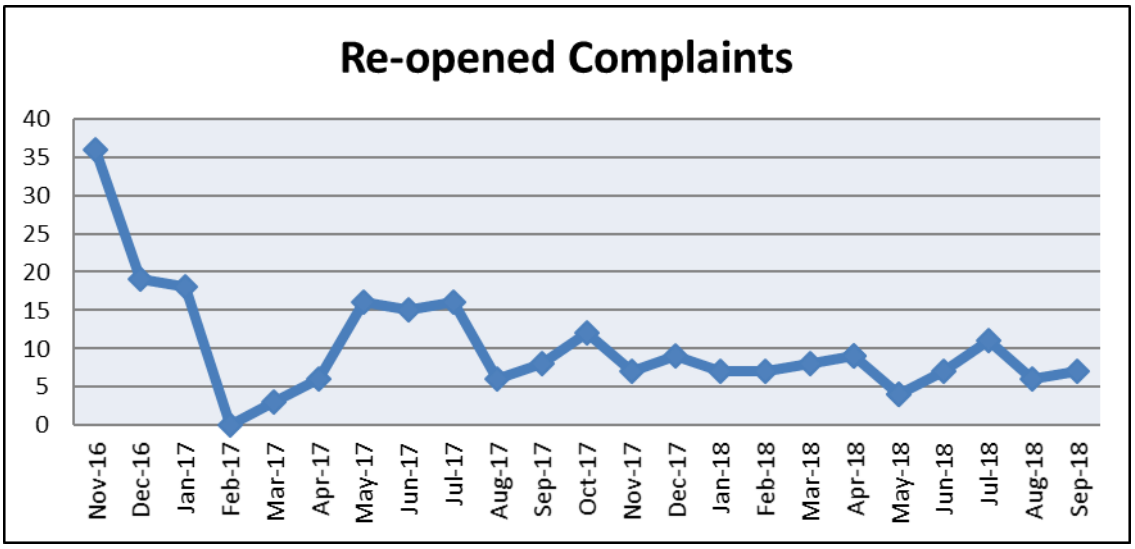
Ward A, Morriston Hospital
"As a family we would like to commend the staff of Ward A at Morriston Hospital for the excellent care and treatment that they provided for my father.
Staff guided us through his operation and recovery treatment answering any questions, giving time to advise us. The staff supported us and the whole team worked with the same ethos providing the best care possible for the patient. The staff brought positivity during a very worrying time for our family. My father was treated with dignity and respect thus providing him with care of the highest standard"

5. CONCERNS MANAGEMENT

During the period 1st July to 30th September 2018, 359 formal complaints were made. Last year for the same time period we received 334 formal complaints that is an increase of 25 formal complaints made this year.

Performance of complaints management is reported in the Quality and Safety Dashboard Report to the Committee and full details of complaint performance is provided in this report to the Committee. The report highlights that the Health Board's performance against the 30 working day target was 80% for the month of August 2018, achieving the 81% target.

The number of re-opened complaints has decreased during 2017/18 when compared to 2016/17 and we are maintaining a low number for the start of 2018/19.

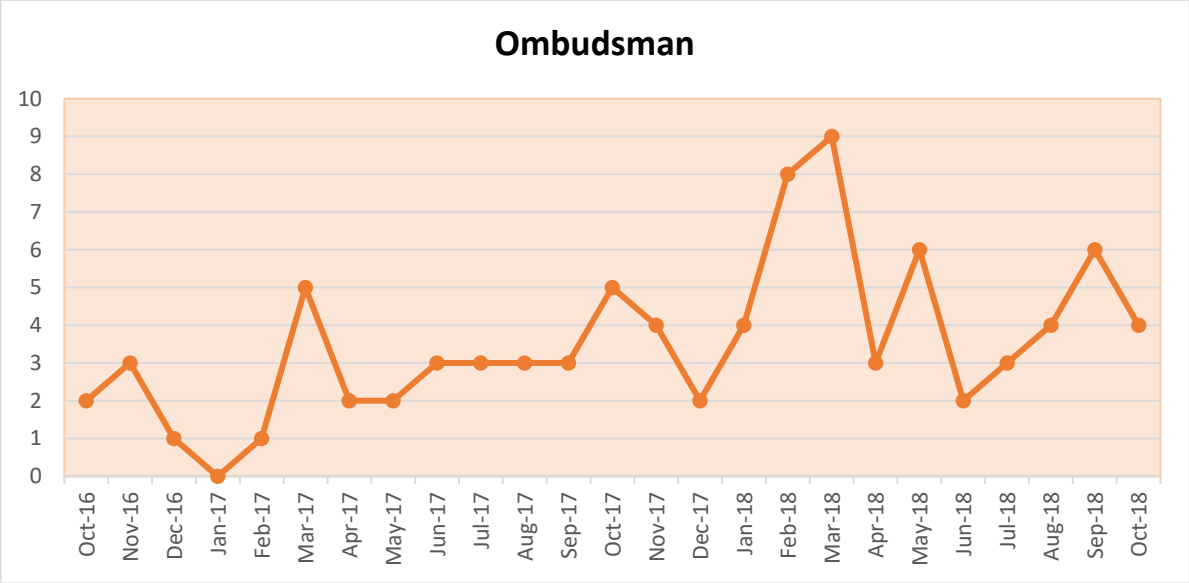


5.1 Concerns Assurance

Monthly audits are continuing on closed Unit's complaint responses through the work of the Concerns, Redress and Assurance Group for Regulation 24 and 26 responses. The audits monitor quality and compliance with Health Board Values, and the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Feedback on the audits is reported currently to the Assurance and Learning Group. Unit Directors and Governance leads for the Units are invited to attend the meetings in order to share information and cascade learning to their respective Units.

5.2 Ombudsman Cases

There has been an increase in complaints which the Ombudsman has investigated in relation to the Health Board in 2017/18, 36 compared to 28 in 2016/17. From the 1st July 2018 – 30th September 2018 we have received 13 new investigations. The Health Board is reviewing the increase to identify the issues resulting in complaints being referred to the Ombudsman for investigating and the Health Board will be taking action to learn and improve following the findings.



5.3 Incidents

For the period 1st July to 30th September 2018 a total of 6627 incidents were reported. The severity of the level of harm of incidents reports is set out as follows

No Harm (1)	4241 (64%)
Negligible (1)	1071 (16.1%)
Minor (2)	1120 (16.9%)
Moderate (3)	178 (2.6%)
Major (4)	9 (0.13%)
Critical (5)	8 (0.12%)
Totals:	6627

From the incidents reported, the top five themes relate to:

- Un-witnessed Trips/Slips/Falls – 670 (10%) incidents
- Pressure Ulcers developed prior to caseload – 594 (9%) incidents
- Moisture Lesion – 488 (7%) incidents
- Inappropriate behaviour towards staff by patient – 434 (6%) incidents
- Pressure Ulcers developed in current clinical area - 327 (5%) incidents

Health Board wide improvement plans are in place to learn from pressure ulcers and falls within the Health Board and the incidents are used to develop the improvement plans following investigations. The two Health Board Groups overseeing these incidents are:

- Pressure Ulcer Prevention Strategic Group and;
- Health Board Falls Group

In terms of inappropriate behaviour the Health Board ensures staff are trained and there are policies and procedures in place to manage these situations. The Health Board takes a zero tolerance approach to inappropriate behaviour to staff and encourages reporting of these events to support risk management in the SDUs. These incidents are monitored through the Health Boards Health & Safety Committee.

6. Patient Safety Solutions

Key Issues to note:

- Health Board is non-compliant with two Patient Safety Alerts both of which have passed the compliance date and two Patient Safety Notices which have passed their compliance date.
- The Medicines Safety Group will review a further two historic notices, PSN 015 – The storage of medicines Refrigerators and PSN 022 – Fentanyl patches Risk of harm from inappropriate use and disposal, in their next meeting.

PSA/PSN No.	Compliance Target Date	Title	Status
PSA 007	01/08/2017	Restricted use of open systems for injectable medication	The alert is being managed by Medicines Safety Group. The alert consists of several components, some of which are compliant. Compliance was discussed at the Medicines Safety Group in September 2018. It was decided that the Health Board cannot declare compliance until all units have complied. The current position is as follows:- - Princess of Wales Hospital Delivery Unit are now compliant - Singleton Delivery Unit are currently developing an action plan. Action plan has been developed and is underway

			only two areas remain non-compliant for Singleton DU. - Morriston Delivery Unit have developed an action plan for some of their non-compliant areas These areas are now compliant. Final action plan awaited for theatres. Discussion ongoing with theatres, some areas in theatre are now compliant, a meeting has been arranged with theatres CD to discuss remaining issues. Compliance will now be discussed at the next MSG meeting. Deadline date 1st August 2017 NON-COMPLIANT
PSA 008	30/11/2017	Nasogastric Tube misplacement: Continuing risk of death and serious harm	The Alert is managed by a Task and Finish Group. A major policy review has been concluded. assurance has been given to Welsh Government Delivery Unit of our steps towards compliance. The task and finish group has been disbanded following successful review and launch of the revised policy. The Nursing and Midwifery Board continue to provide guidance and consult on the training plan which will accompany the revised Policy. Training for nurses has been agreed, ratified by the Nursing and Midwifery Board and `train the trainer` sessions were held on 22nd October. The named clinical lead for Nasogastric Tube issues is now the Deputy Medical Director who will now also take on responsibility for the issues regarding medics and radiology competency. A final meeting of the Task and Finish Group will be arranged to assess compliance following a reply. Deadline date 30th November 2017. NON-COMPLIANT
PSN 030	26/08/2017	Construction of medicine cupboards	The Clinical Director of Pharmacy is leading on this alert. The MARRS self-assessment has been completed, an action also been completed and submitted to Welsh Government. The Welsh Government issued a new questionnaire it was returned to Welsh Government. On the basis of the responses PSN 030 is being redrafted. The new draft will: 1) Include a statement at the beginning setting it in the context of the wider MARRS work 2) Include a statement regarding a proportionate implementation approach (from mandatory for new builds and refurbishment to risk assessed approach to other areas) and need for risk assessments to be conducted 3) Include standard risk assessment form as annex to PSN. 4) Reflect the concerns expressed in response to the PSN where appropriate to do so. Advice has been sort from Patient Safety Solutions on when PSN

			030 will be re-issued. NON- COMPLIANT
PSN 045	1/04/2019	Resources to support safer modification of food and fluid	The Alert was referred the Health Boards "High Risk" meeting13th August for executive advice on the best way to take this alert forward. The Director of Therapies and Health Science has appointed a lead from Speech and Language Therapies to work on the notice. Feedback was provided to the Nutrition Steering Group on 13th Sept 2018 re progress to date. The implementation group has: • Cascaded the safety alert to all areas to highlight IDDSI changes • Agreed and implemented a switch from Resource Clear ThickenUp to Nutilis Clear for the modification of fluids • Assurance provided that all hospitals and community are now using IDDSI terminology for fluids • A meeting is arranged with the supplier of modified diets on 18th Nov to discuss change to IDDSI terminology for diets provided in hospital • Community services have already received training and have implemented IDDSI terminology for diets • SLT and dietetic training at nurse induction uses IDDSI terminology • Plan to use Nutrition and Hydration week, March 19, to promote change to IDDSI terminology for modified diets at all hospital sites A meeting has been arranged to review the progress of the implementation plan for fluids, and to discuss the training requirements for the changes needed to make our diets compliant with IDDSI terminology. Deadline date 1st April 2018. NON-COMPLIANT

7. Arts in Health

Patient Stories

Patient Stories are a very effective tool for learning and stimulating service improvement. Many of the stories are part of resolving serious complaints.

Over the last six years the Arts in Health Coordinator has made more than 100 digital patient stories for ABMU.

Some examples of what digital stories have achieved:

- Prevented incidents escalating to court
- Transformed incident reporting at POW
- Improved the complaints handling process
- Precipitated a review of family witnessed resuscitation
- Improved training in end of life care
- Provided patient and staff views on visiting hours
- Provided patient views on services such as perinatal mental health
- Stimulated new projects addressing patient boredom
- And many other examples…

Over the last six months we have worked with the patient feedback team to write the standard operating procedures and establish digital patient stories as mainstream ABMU practice.

In November we will be launching a share point site where staff can access a library of stories to use in meetings and training. They will also be able to access the standard operating procedures, submission form and training applications.

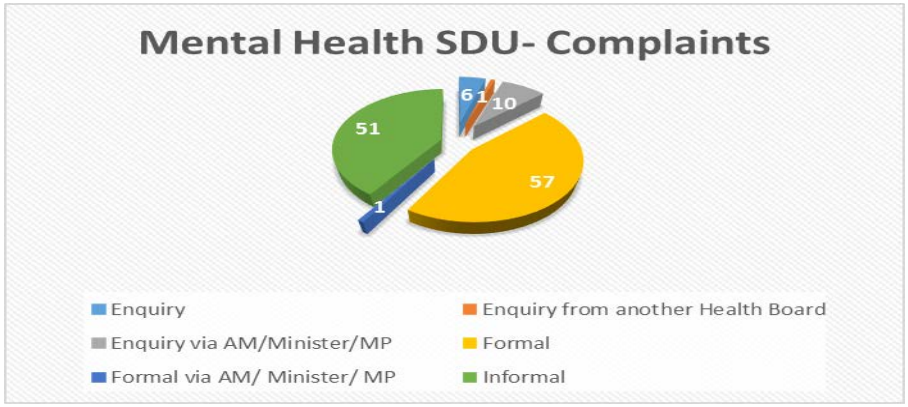
It is agreed policy that each SDU will have two trained story facilitators and a new accredited training course starts in January 2019.

8. SERVICE DELIVERY UNIT REPORTS

Mental Health & Learning Disabilities Service Delivery Unit

1st July- 30th September 2018

Mental Health & Learning Disabilities SDU received 53 concerns.



Top 3 Complaint Trends

➢Communication issues (23)

➢Appointment (18)

➢Attitude & Behaviour (16)

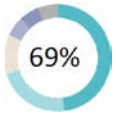
➢No never events
➢3 personal injury claims
➢1 clinical negligence claim

MH & LD

973 incidents were reported with the 3 top themes being:

- Inappropriate/Aggressive Behaviour towards Staff by a Patient – PICU (55), Ward F NPT (17) and Clyne Ward Cefn Coed (17).
- Inappropriate/Aggressive Behaviour towards a Patient by a Patient– Clyne Ward (19), PICU (16) and Suite 2 Tonna, Llwyneryr, and Fendrod Ward (12 each)
- Self-harming Behaviour - Clyne Ward (39), Newton Ward (31) and Ward F (NPTH) (14)

Serious Incidents – 11 (Unexpected death 7, Patient accidents/falls 4)



Friends & Family Results – July - September 2018
of 45 respondents said they would be extremely likely or likely to recommend the clinical service.

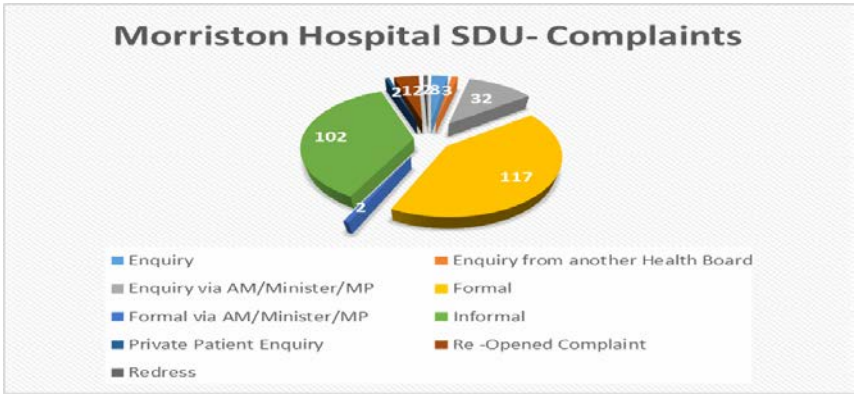
There were three All Wales Surveys completed for the Service Delivery Unit during July - September 2018. With the overall score 0%.

Compliment: "HUGE thank you to you to ALL nursing and support staff on Ward 14 PoWH for the compassionate care that I received during my brief 5 day admission. Your empathy and kindness made a massive difference".

Morriston Hospital Service Delivery Unit

1st July- 30th September 2018

Morriston Hospital SDU received 280 concerns.



Top 3 Complaint Trends

- Communication issues (127)
- Clinical Treatment (125)
- Admissions (100)

22 Clinical Negligence Claims
4 Personal Injury Claims

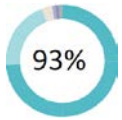
No Never Events

Incidents

1,670 incidents were reported with the 3 top themes being:

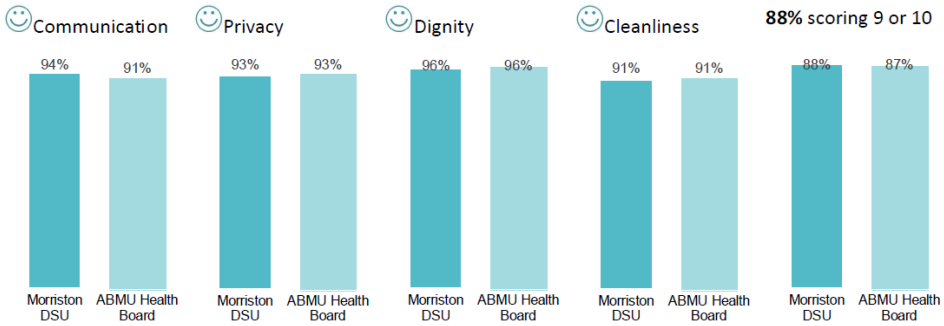
- Suspected Slips/Trips/Falls (un-witnessed) – Gower Ward (19), Ward T (17), Ward S (14)
- Moisture Lesion – General ITU (19) Accident & Emergency Department (16), Acute MAU (12)
- Injury of unknown origin – General ITU (18) Ward S (9), Ward T (9)

Serious incidents - 4 (no themes)



Friends & Family Results – July to September 2018
of 3,842 respondents said they would be extremely likely or likely to recommend the clinical service.

All Wales Survey



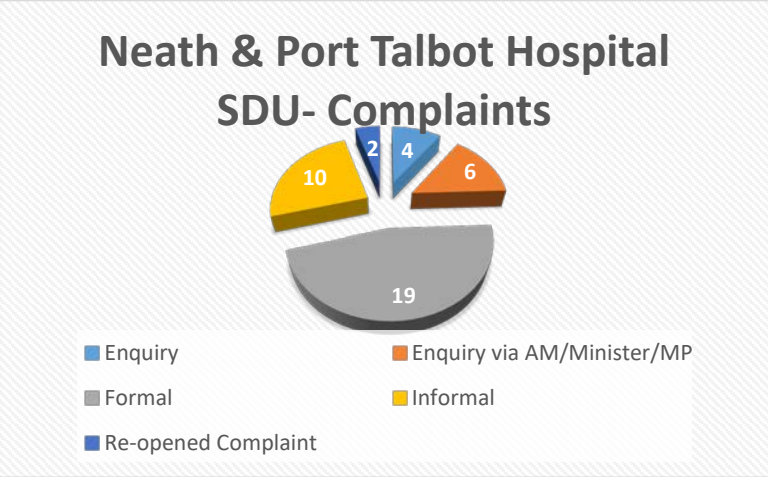
222 All Wales Surveys were received for the Service Delivery Unit during July to September 2018.

Compliment: "The nurses and healthcare staff were great and always informative and up beat, they gave us the support we needed at a difficult time. We were always very well informed by them and the doctors too".
Short Stay Cardiac Unit

Neath Port Talbot Hospital Service Delivery Unit

1st July – 30th September 2018

Neath Port Talbot SDU received 41 concerns.



Top Complaint Trend

- Communication issues (26)
- Clinical treatment (22)
- Attitude & Behaviour (13)

- 0 Personal Injury claims
- 1 clinical negligence claims
- No never events

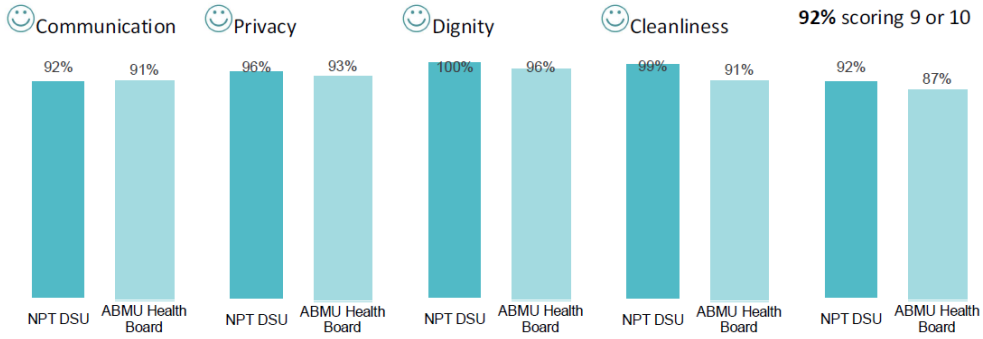
Incidents:

- **281** incidents were reported with the 3 top themes being:
- ❖ Suspected Slips/Trips/Falls (un-witnessed) – Ward D (29), Ward C (24) and Ward B2 (23)
- ❖ Witnessed Slips/Trips/Falls – Ward B2 (8), Ward C (5) and Ward D Ward E (4 each)
- ❖ Other Service Disruptions/ Infrastructure Incident– Ward D (7), Ward C (6), and Ward B2 (3)

Serious Incidents – 3 (2 patient accidents/falls)

Friends & Family Results – July to September 2018
of 1,886 respondents said they would be extremely likely or likely to recommend the clinical service.

All Wales Survey



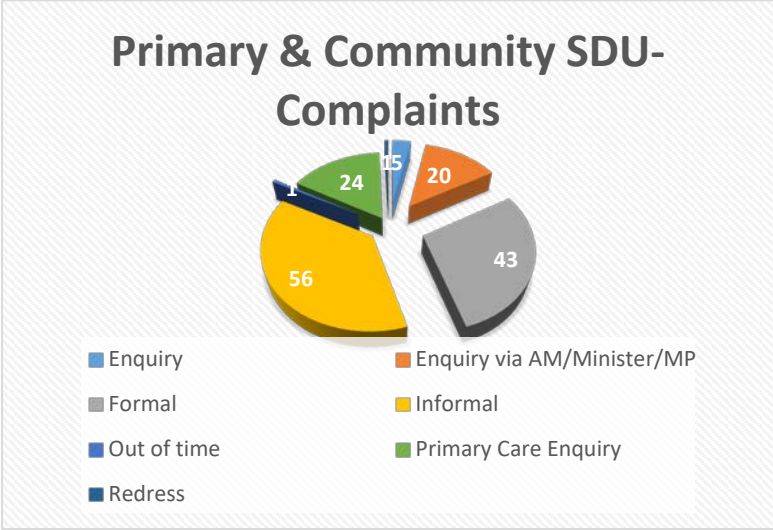
83 All Wales Surveys were received for the Service Delivery Unit during July to September 2018 with the overall score of 92%.

Compliment "Today I brought my granddaughter to the Minor Injury Department. I would like to thank the receptionist, triage nurse, X-ray department and the nurses who looked after her. You all deserve a medal for you care when treating a child. Amazing techniques to make her feel safe and taking her mind off the procedure. The teddy made her day" Minor Injuries Unit

Primary & Community Service Delivery Unit

1st July- 30th September 2018

Primary & Community SDU received 150 concerns.



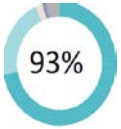
Top 3 Complaint Trends

- Appointments (67)
- Communication (52)
- Clinical Treatment (51)

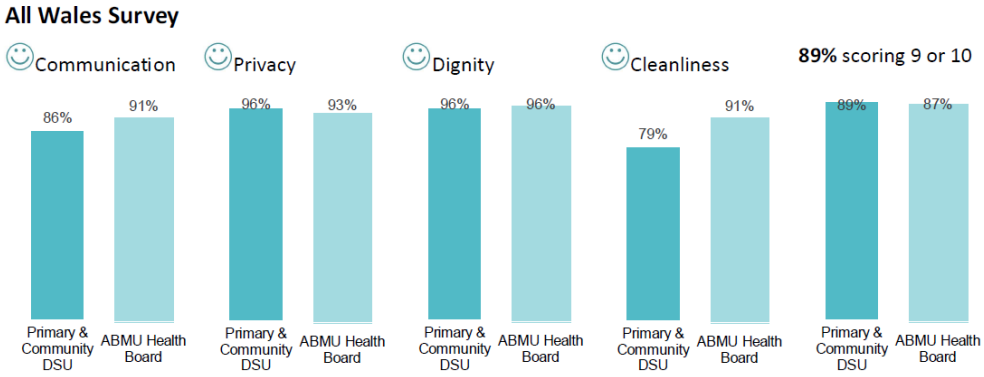
➢No never events
➢No personal injury claims
➢1 clinical negligence claim

Incidents:
1288 incidents were reported with the 3 top themes being:
❖ Developed in current clinical area/caseload – Patient's home (94), City Health Central Hub (13) Bay Health West Hub (13)
❖ Moisture lesion – Patient's home (97), Bay Health West Hub (29) City Health Central Hub (17),
❖Injury of unknown origin – Patients Home (35), Bay Health West Hub (10) City Health Central Hub (9).

Serious Incidents (26) – Pressure ulcers (25)



Friends & Family Results – July to September 2018
of 466 respondents said they would be extremely likely or likely to recommend the clinical service.



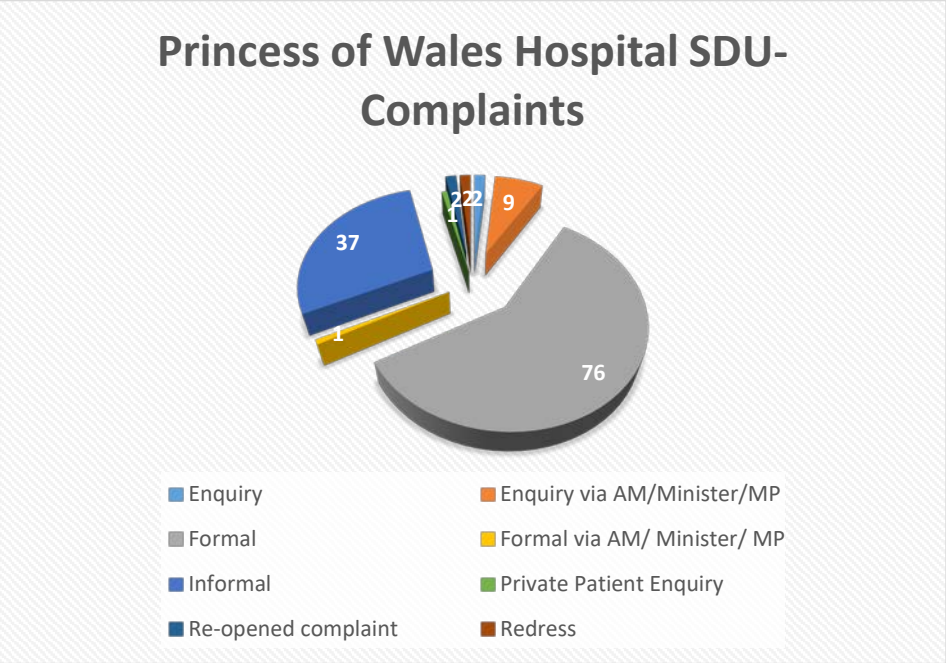
78 All Wales Surveys were received for the Service Delivery Unit during July to September 2018.

Compliment received:- Many thanks for looking after my dad so well in the weeks he spent in Gorseinon Hospital. Dad is feeling and looking so much better and is now ready for home following the care he has received for his wound and the physio to help him walk again. I expect dad to continue to recover at home and be back to his usual self thanks to your care." **Gorseinon Hospital**

Princess of Wales Hospital Service Delivery Unit

1st July- 30th September 2018

Princess of Wales Hospital SDU received 130 concerns.



Top 3 Complaint Trends

- Communication Issues (65)
- Clinical treatment (55)
- Admissions (28)

19 Clinical Negligence Claims

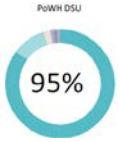
No Personal Injury claims
No Never Events

Incidents:

1159 incidents were reported with the 3 top themes being:

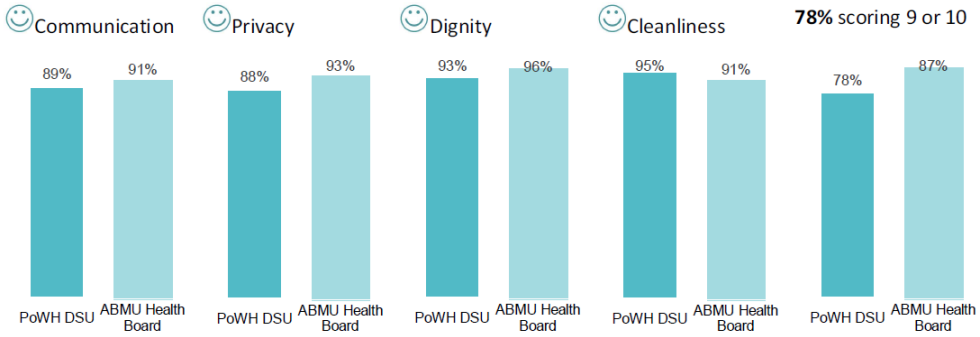
❖ Suspected Slips/Trips/Falls (un-witnessed)– Ward 20 (16), Ward 19 (14), Ward 5 (POWH) (13)
❖ Maternity Triggers – Labour Ward / Central Delivery Suite (68), Labour Ward/Delivery Room (24), Ward 12 (8)
Moisture Lesion– Ward 5 (20), A&E (12) and Ward 20 (11)

- **Serious Incidents - 6** – (Pressure Ulcers- 4, Patient Accident/Falls- 2)



Friends & Family Results – July to September 2018
of 3,191 respondents said they would be extremely likely or likely to recommend the clinical service.

All Wales Survey



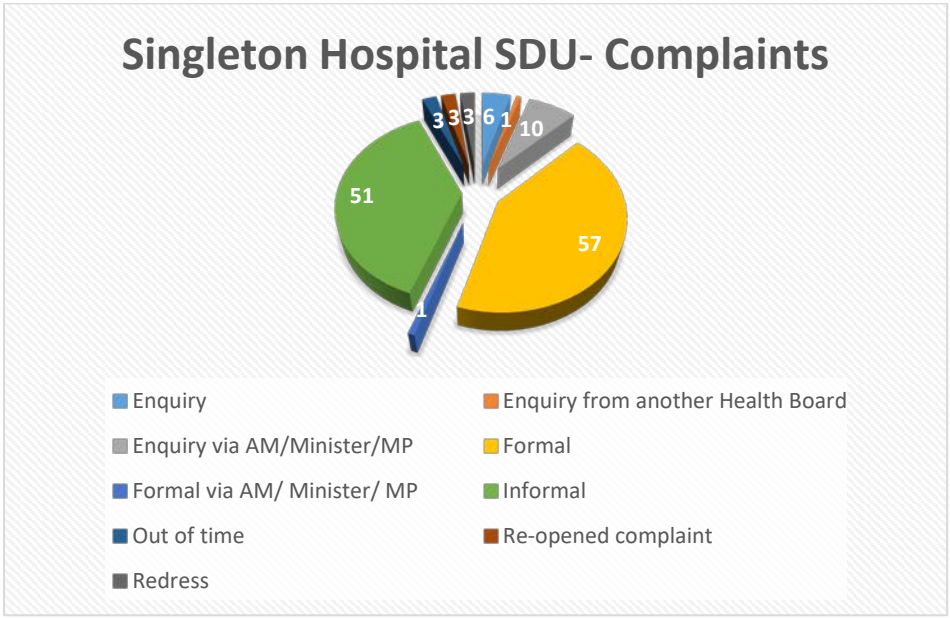
87 All Wales Surveys were received for the Service Delivery Unit during July to September 2018.

Compliment: I returned home today having spent 26 days on ward 9, following a holiday illness which led to further complications.
At a time when people are quick to be so negative about the NHS, I feel I have to pass on my impressions. I have never been treated so well by people who are obviously extremely busy, but still manage to cater for all patients' needs, and all whilst being pleasant and smiling". Ward 9

Singleton Hospital Service Delivery Unit

1st July – 30th September 2018

Singleton Hospital SDU received 135 concerns.



Top 3 Complaint Trends

- Communication issues (63)
- Appointment (55)
- Clinical Treatment (54)

15 Clinical Negligence Claims

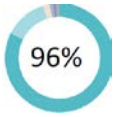
No never events
1 Personal Injury claim

Incidents

1159 incidents were reported with the 3 top themes being:

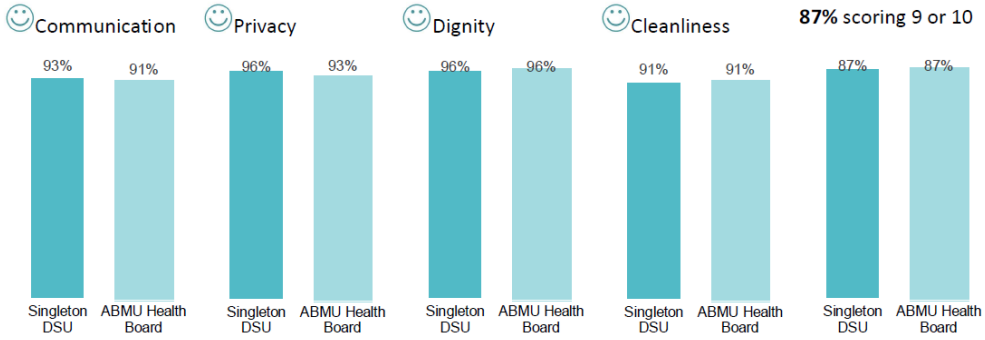
- Maternity Triggers – Labour Ward / Central Delivery Suite (91), Labour Ward/Delivery Room (22) and Ward 18 (12)
- Suspected Slips/Trips/Falls (un-witnessed)– Ward 6 (28) Ward 3 (26) and Ward 4 (10)
- Laboratory Investigations/Interpretations – Laboratory (40), Pathology Department (7), 11 other locations (1 each)

Serious incidents - 3 (not themes)



Friends & Family Results – July to September 2018
of 5,896 respondents said they would be extremely likely or likely to recommend the clinical service.

All Wales Survey



129 All Wales Surveys were received for the Service Delivery Unit during July to September 2018.

Compliment "I must write and thank you for a wonderful department. Each member of staff greeted me with a smile. The CT scan is not the most pleasant of procedures but everyone showed great showed great patience, kindness and courtesy. You have trained your staff so well, we all love the NHS and some of you deserve medals!". **Radiology Department**

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Annual Concerns & Claims Report

2017-2018

EXECUTIVE SUMMARY

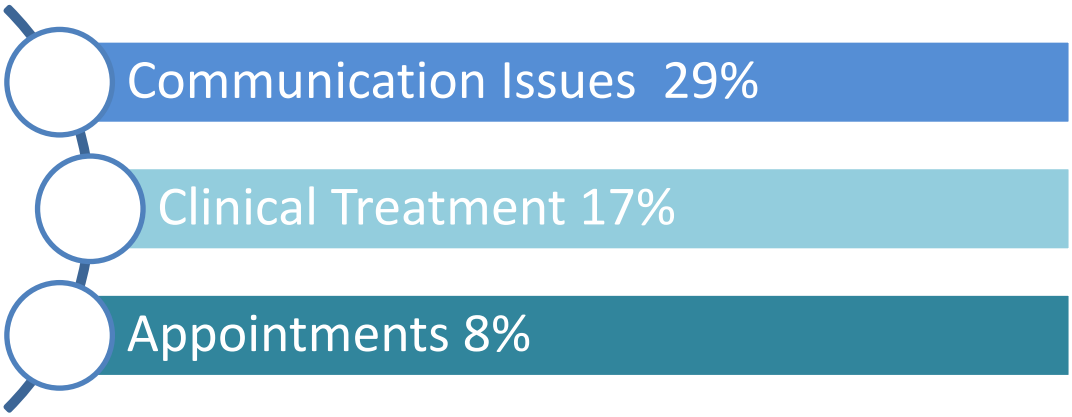
The annual Concerns and Claims Report provides details on the Health Board's performance against the requirements under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. *This is the sixth report the Health Board has completed.*

2017/18 was the fourth year of the Patient Experience, Risk and Legal Services merging as one team with a focus on:

- Individually acknowledging every complaint and the complainant, where possible, spoken to via telephone to discuss their complaint;
- Increased openness and involvement with the patient/family representative throughout investigations;
- Continuation of the "Lets Talk Campaign" which is designed for patients and staff to speak up and report concerns so that the Health Board can continually learn and improve the services we provide;
- Continual development of the Datix Web Risk Management Database to enable real time data and ensure it remains fit for purpose. This work has resulted in the Health Board being awarded reference site status in recognition of the development of the system and the Health Board has maintained this during 2017/18.

The Health Board received 1,356 formal complaints which is a slight increase (9%) when compared to 1,249 complaints being received in 2016/17. Informal complaints have decreased by 8% from 1,101 received in 2016/17 to 1,021 during the year.

During the year key themes, from concerns upheld, related to:



Communication was the top theme for 2016/17 and remains the top theme for 2017/18. Communication accounted for 29% of the complaints upheld in 2017/18. The Health Board's Patient Advice and Liaison Teams (working in Morriston Hospital, Princess of Wales Hospital, Neath Port Talbot Hospital and Singleton Hospital) are working with the Patient Experience Team to support work to reduce the number of complaints for communication issues.
Action being taken to reduce communication concerns include:

- **Training** for staff focusing on the Five Star presentation incorporating communication, Health Board values and the three domains of Patient Experience. These standards are set out in: *Key Determinants of a Good Service User Experience* which are based on national and local published evidence.
  Attendees at these sessions are staff in a position to drive the initiative back at the workplace. Each training event lasts up to 1.5 hours and is interactive and assists staff in star rating their own ward or department against *Key Determinants of a Good Service User Experience.* To achieve this, the trainer designed a bespoke document that also included the Health Board's Values Framework. Feedback from these sessions has been very positive. A number of bespoke sessions have been planned for 2018. In the main these will be provided under the heading of Customer Care with a clear focus on communication skills.
- **Reviewing the roles of the Patient Advice Liaison Service (PALS) Officers** to focus on early resolution of communication concerns.
- **Analysis of themes of communication concerns** to enable an inpatient plan to be developed.

Clinical treatment was the second highest theme with 17% of complaints in this theme, with the majority relating to delay in receiving treatment.

Appointments was the third theme of the most upheld complaints with 8% of complaints upheld. Improving this area of our services is a priority for the Health Board to take forward and a number of actions are being taken to improve performance. While there has been some improvements in terms of reducing the number of patients waiting to start treatment and number of people waiting over 36 weeks, the Health Board recognises that further work is required to reduce the waiting times further and the Board is taking action in this respect. Improving access to services for patients remains a priority for the Health Board.

Further information on the action being taken to improve waiting times for appointments and treatment is provided in the Health Boards Annual Report which can be accessed through the Health Boards Intranet: www.abm.wales.nhs.uk

Looking back in terms of external investigations and reports relating to concerns and claims management the Health Board has had:

- No new public interests (Section 16/17) Ombudsman Reports received in 2017/18 and the last report was received in 2015/16.

- Four Regulation 28 reports were issued by Her Majesty's Coroner in relation to inquests involving the Health Board where the Coroner recommended action to prevent future deaths occurring compared to four in 2016/17. Please see section 18 for more details of these reports and the action the Health Board has taken.

All concerns provide an opportunity for learning and they are a valuable method of us knowing where we can improve. We want to reduce these wherever possible and to give patients and our staff a service they can be proud of. Section 12 of this report provides details of some lessons learned/actions taken to help minimise recurrence following investigations of concerns.

The report sets out the organisational arrangements for the management of concerns and the number of cases managed within the period. Setting this information against the number of patient contacts we have as an organisation demonstrates that complaints and incidents are rare and that the vast majority of the people we see are satisfied with the care and treatment the Health Board provides. Supporting this statement the percentage of patients who would highly recommend the Health Board Services to Friends and Family in 2017/18 was 95%.

1. Background to the NHS Redress Regulations 2011

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 came into force on the 1st April 2011. These Regulations apply to all Welsh NHS bodies, primary care providers in Wales and independent providers in Wales providing NHS funded care. The Redress elements of the Regulations and the guidance relating to those aspects do not apply to primary care practitioners or to independent providers.

These Regulations require a proactive approach to acknowledging and putting things right when patients have suffered harm or poor experience. They were designed to streamline the handling of Concerns. Under the new *Putting Things Right*

arrangements, ABMU Health Board has improved its performance against the principles of the guidance, to "investigate once, investigate well", ensuring that concerns are dealt with in the right way, the first time round.

2. Arrangements for the handling of concerns

The Health Board's Non Officer Member who has oversight for the handling of concerns in 2017/18 was Mrs Maggie Berry and is also the Chairman of the Quality & Safety Committee. Mrs Berry's role is to ensure the Board is provided with an appropriate level of assurance in respect of managing concerns.

The Director of Nursing & Patient Experience is responsible for ensuring compliance with regulations and is supported by the Deputy Director of Nursing & Patient Experience. While the Director of Nursing & Patient Experience has direct responsibility for the management of the Department the Medical Director and the Director of Nursing & Patient Experience share responsibility providing leadership and support in the handling of concerns and claims.

In 2017/18 revised management arrangements were implemented with six Service Delivery Units replacing the eleven Directorates and Localities management arrangements. Each of these Units has in place a Quality and Safety Team who investigate their incidents and complaints (concerns). The focus of the Units is responding to concerns with quality, timely responses, ensuring shared learning across the Units as a priority. The Patient Experience, Risk and Legal Services Team support the Units in terms of strategic direction and performance management to improve the quality of responses to complaints and improving the timeliness of the responses issued.

4. Concerns - Safety Incidents

A total of 25,134 incidents were reported during the year the majority of which related to no harm incidents (77.97%). The degree of harm and level of harm is provided in Table 2.

Table 2

Table	Green	Yellow	Amber	Red
Incident Reported Date	**No/V Low Harm/ Damage**	**Minor Harm/ Damage**	**Moderate Harm/Damage**	**Severe/V Severe inc Death**
2008/2009	**69.89%**	**25.63%**	**3.47%**	**1.00%**

2009/2010	**72.00%**	**25.45%**	**1.80%**	**0.76%**
2010/2011	**75.92%**	**21.40%**	**1.84%**	**0.77%**
2011/2012	**87.60%**	**10.60%**	**1.02%**	**0.68%**
2012/2013	**89%**	**8.50%**	**0.98%**	**0.74%**
2013/2014	**89%**	**8%**	**1.56%**	**0.66%**
2014/2015	**84.42%**	**13.04%**	**2.18%**	**0.35%**
2015/2016	**81.7%**	**14.6%**	**3.2%**	**0.32%**
2016/2017	**80%**	**17%**	**3.3%**	**0.34%**
2017/2018	**77.97%**	**18.80%**	**3.25%**	**0.30%**

The Health Board purchased Datix Web Risk Management database during 2014/15 and implemented the system on 1st December 2014. As a result staff following completion of incidents receive automatic feedback when the incident is closed setting out the lessons learned and actions taken. Staff were consulted on with the design of the incident form as a result of which there has been an increase in incidents reported which provides the Health Board with an opportunity to learn lessons from no harm incidents.

It is also compulsory for feedback to be a specified action in any action plans developed in response to complaints, incidents and claims.

5. Serious Incidents

The Health Board submits details of 'serious incidents' to the Welsh Government. Welsh Government define a Serious Incident to include incidents where there is media interest, ‘never events’ (such as chemotherapy drugs given via the wrong route, wrongly prepared high risk injectable medication, maladministration of Insulin) and unexpected deaths. The reporting criteria are not based purely on the level of harm.

During the year, 285 serious incidents were reported to Welsh Government, these included pressure ulcer incidents, reports of bed closures due to outbreaks of infection within our hospitals.
ABMU introduced a standard operating procedure for the investigation of never events and serious incidents in January 2015, which was reviewed and updated in 2015/16, to ensure rapid investigation and reporting of never events, resulting in timely actions being taken and learning within the Health Board. The protocol will be further reviewed in 2018/19.

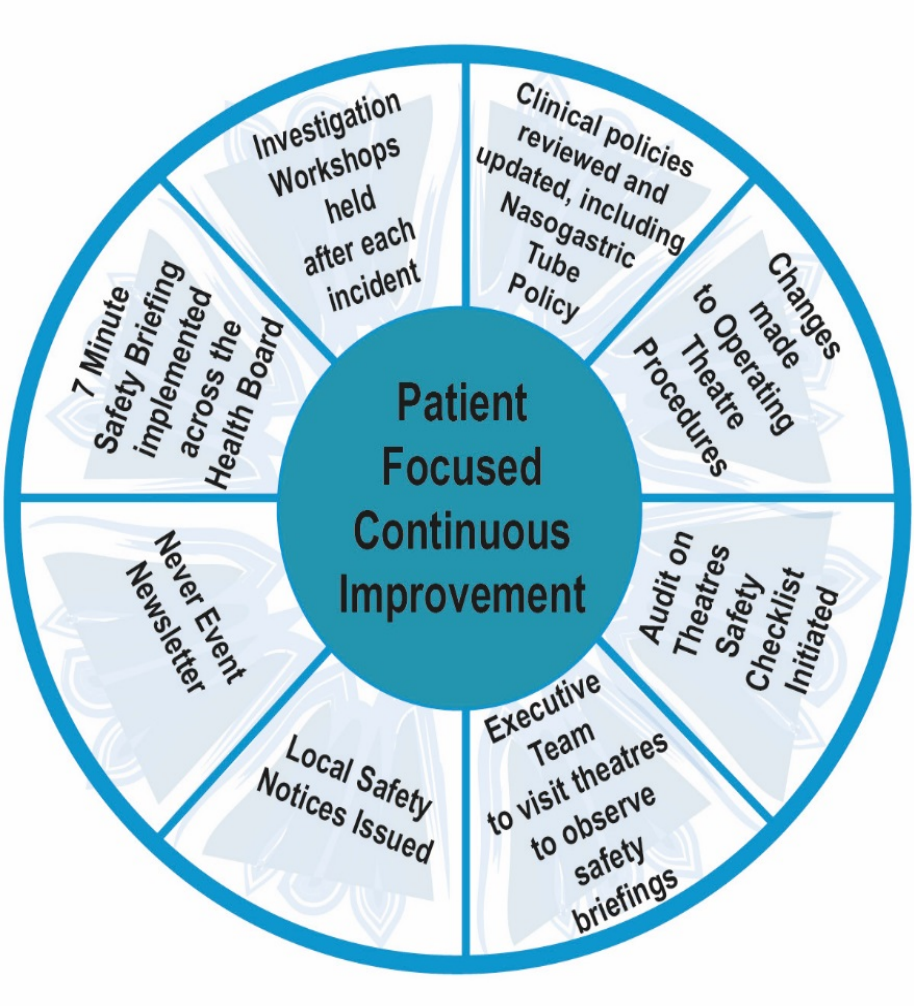
5.1 Never Events during 2017/18

During the year 10 incidents occurred that we call ‘Never Events.’ These are incidents that all NHS organisations should have robust systems and processes in place to prevent them occurring. All events have been fully investigated and as a result changes are being made to improve patient safety.

These events related to:

- Wrong surgical component being used;
- Wrong site surgery;
- Retained swab; and
- Wrong route medication.

The Health Board accepts that these events should not have occurred and has taken action as a result of the findings in the investigation reports and shared these with the patients/family involved. The learning from these events includes:



6. Concerns – Complaints

Complaints can be received at any place across the organisation, and not all complaints are resolved using the formal process. The Health Board is required to report performance against compliance with the timescales recommended within the NHS Redress measure and via the Putting Things Right Guidance. A grading system is in place which considers the severity of the concern to promote a suitable level of investigation to be undertaken.

Concerns graded-
Green or yellow, or Multi yellow are subject to 30 days maximum target timescale, this can be extended in complex cases as is often the case in Multi yellow concerns

Amber/Red are subject to a 30 day target timescale although often these graded concerns are complex and in such cases the timescale for investigation can be extended to 6 months, although the Health Board, where possible, will aim to complete the investigation within 30 days.

Performance in relation to timely complaint responses is provided in 6.2.

6.1 Developments lead by the complaints team include:

- The Health Board continues to work with external stakeholders e.g. the Community Health Council (CHC). The Deputy Head of Patient Experience and Concerns holds regular meetings with the Deputy Chief Operating Officer to improve and develop working relationships. The aim of the meetings are to jointly review the CHC complaints sent to the Health Board to share information, identify trends and to support good working relationships between the two organisations. During 2017-18 there has been a considerable reduction in the number of escalation process by the CHC due to the continuing close working relationship with the external stakeholders. Going forward the SDU Governance Leads will be invited to attend the external stakeholder meetings.

- The Corporate Patient Experience & Concerns Trainer, as a consequence of the continuing theme of Communication in complaints upheld, has concentrated on delivering training for staff on “nipping complaints in the bud”. Also the training covers behaviours and behavioural change. Bespoke training sessions for areas identifying continual themes of communication have been completed across the Health Board.

- A Concerns and Redress Assurance Group is in place to audit and monitor complaint response compliance from the 6 SDUs and meets on a monthly basis. Feedback and learning form this group is reported at the Assurance and Learning group meetings. Terms of Reference of CRAG have been reviewed and representatives from the SDUs are invited to attend peer review meetings to focus on continuous improvement and learning.

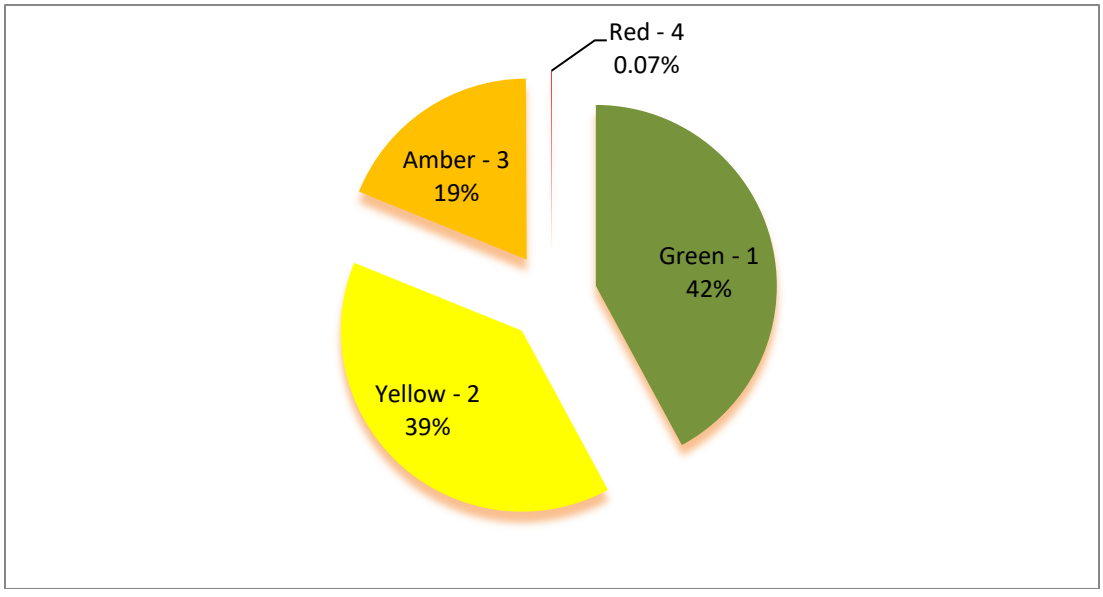
- Workshops and training has been delivered to support the SDUs in the management of concerns and redress cases. The workshops promote an ethos for good investigation of complaints and complainant responses and the importance of timely responses. The Ombudsman Improvement Officer has also presented at these workshops. The workshops complement the Mental Health and Learning Disability SDU Improvement plan and provide for staff the tools to respond to complaints in line with the Regulations. Specific training request by Mental Health Senior Staff has been held.

- The Health Board continues to operate a process with the aim of contacting complainants on receipt of a concern, and a meeting offered to the complainant. Complainants are now updated regularly on the progress of the complaint.

6.2 Complaints – Activity and Performance

During the financial year of 2017/2018 the Health Board received 1,356 formal and informal concerns totalled 1,021for the year.

Below is a pie chart which shows the percent of complaints by grades received during 2017/18.

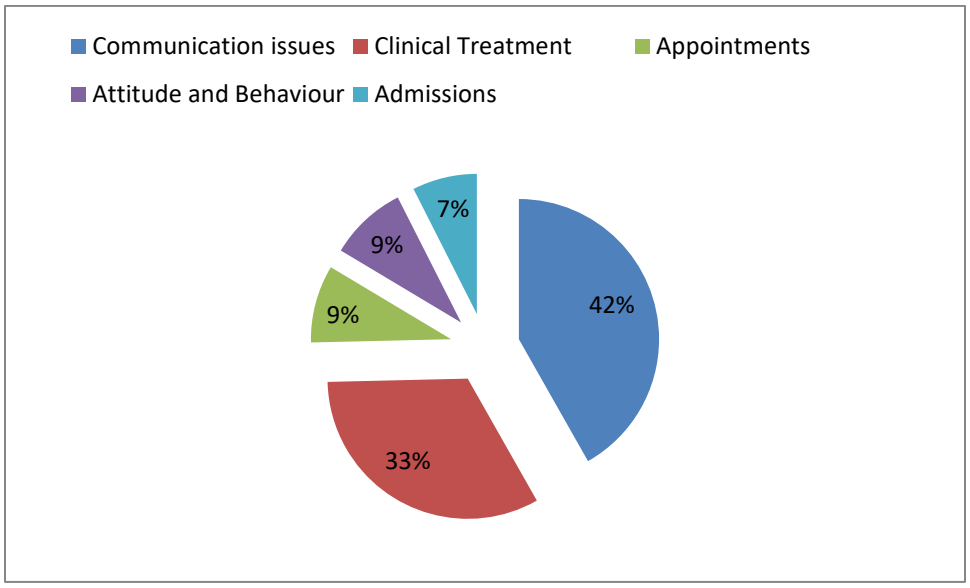


As you can see the majority of concerns received are severity graded Green and Yellow, grading is based on the contents of the complaint information provided in relation to harm. Many complaints have more than one element of dissatisfaction, although each complaint will have a primary subject.

6.5 Type of Complaint Received

The top five types of formal complaints received are provided in the pie chart below, 42% relate to communication issues.

Top 5 complaint themes



To meet the requirements of the NHS Redress Regulations, the Health Board aims to respond to complaints within 30 working days. If there are reasons why this cannot be achieved – for example in cases where the complaint is complex and/or of serious nature- a timescale is discussed and agreed with the person raising the complaint. This should be no longer than six months.

The Health Board's compliance with those concerns expected to achieve a response within 30 working days was 78% in 2017/18 achieving the Welsh Government target of 75%. The Health Board will aim to sustain performance in 2018/19.

7. Compliments

A total of 1649 compliments were recorded in 2017/18. Compliments recorded include: formal letters/correspondence expressing gratitude and appreciation for treatment. Many more cards, letters, and gifts were also sent directly to clinical teams and wards from grateful patients and relatives, which have not been formally recorded.

Examples of compliments received during 2017/18 include:

'The consideration which my son was shown by the whole team, was in my experience such a wonderful example of good practice. The time taken to get to know my son as an individual and not as an autistic person was so heart warming and so important. Continuity is also very important to people with autism due to their high levels of anxiety. This was taken into consideration when my son met the theatre staff, as well as the Anaesthetist and the Dentist at the pre-assessment and the same team were there to welcome us on the day of his treatment. Besides their caring, patient approach they also took time to ascertain my son's sensory needs so that he was relaxed and comfortable as possible. Whilst my son is not able to express his feelings verbally, he certainly is able to do so in his demeanour. The time taken to communicate to him prior to the treatment and the attention he received in the recovery room contributed to a rapid recovery physically and emotionally once he returned home.' ***Theatres, Princess of Wales Hospital***

'I would like to convey my sincere thanks to you and the Community Independence Team for the excellent service they have provided not only to my niece but to us as a family. Before your support we obviously were trying to help my niece live as independently as possible. This was proving to be quite difficult with the limited resources we knew were available for her condition. The involvement of your team has made a tremendous difference to ourselves. They have provided a quick professional service which has helped her to remain in the comfort of her own home. We really must compliment everyone involved as they have all been friendly and keen to help. Such great service is to be commended and I would appreciate you pass my thanks and appreciation to all concerned. Once again many thanks and I would like to you know how fortunate we are to have yourself and a team such as yours operational in our community.' ***Community Resource Team, Trem-y-Mor***

'I would like to thank you all for the great care and treatment I have received from you over these past weeks. The treatment you have given me and the way you have helped and looked after me has been great. I have found the manner in which you have cared for me to be very kind, professional and efficient. Please could you pass this message on to every staff member who visited me, because of all of your hard work my leg is now nearly fully recovered. which I am very grateful for.' ***District Nursing Team, Clydach, Swansea***

'I was admitted to Morriston Hospital A&E because of a head wound on the morning of 12 July 2017 around 4:30am. I waited for probably two hours and was seen by the doctor later on. She treated me professionally and sympathetically, giving me good care as well as a sense of importance. She was methodological and thorough in her treatment, making me feel at ease while efficiently treating the wound, letting me know what is going on at any step. It took her probably between 40 minutes and an hour to treat me. Then I understand why I had to wait so long – because every patient is so carefully looked after by the medical team here. I am very thankful to the doctor and to Morriston Hospital.' ***A&E, Morriston Hospital***

'I would like to comment on the excellent service I received today whilst visiting the Audiology department at the Neath and Port Talbot Hospital .The audiologist who dealt with me was professional and able to answer all my queries whilst making me feel at ease.' ***Audiology Unit, Neath Port Talbot Hospital***

8. Referrals to Public Service Ombudsman (PSO) for Wales

During 2017/18 the Ombudsman saw an increase in complaints being referred when compared to 2016/17.

The table below sets out the number of referrals made and number investigated by PSO. An analysis of the findings of the early settlements uphold complaints in full or part has been shared with the Quality and Safety Teams in the SDUs to learn from the findings and improve our services and management of complaints.

	2016/17	2017/18
Complaints referred to the PSO	96	121
Number of complaints PSO investigated	26	37
% of cases upheld in full or part or voluntary settlement	25%	42%

The main themes from the Ombudsman continue to include in-hospital treatment, complaint handling, missing records and/or record keeping and communication.

There have been no Public Interest Section 16 reports for the Health Board for this period.

9. NHS Redress

Under the NHS (Concerns, complaints and Redress Arrangements) (Wales) Regulations 2011 arrangements, the Health Board is required to identify those complaints 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 the 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.

Due to the nature of the Redress process whilst these concerns will have had a response, consideration of Redress or acceptance of the Redress Offer was ongoing at the end of the year and will be resolved during 2018/19.

The Health Board settled 64 redress cases (56 complaints and 8 incidents) in 2017/18 compared to 72 redress cases during 2016/17.

Training on redress continues with the Legal Services Team providing training to SDU teams as part of Managers training on the Managing to Deliver Programme on a quarterly basis and six monthly to clinicians on the Consultant Development Programme. In addition Concerns and Redress Workshops have been held during 2016/17 and 2017/18 to support the SDUs in complaints and redress management.

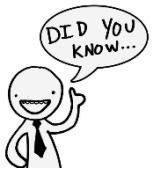
10. Patient Experience

The Patient Experience Unit continues to provide support and guidance to the SDUs on increasing the number of patient feedback surveys completed and has been involved in the following developments during 2017/18:

Five Star Patient Experience: The Five Star Patient Experience training is still a priority of the Board, and several training events have taken place and more sessions are planned. Wards/departments who have attended this training have seen an increased response rate to the Family and Friends Test Cards. Staff attending the event have provided very positive feedback and have appreciated the support for increasing Family & Friends response rates.

iPad Pilot: A pilot of roaming electronic devices such as tablets and iPads took place in the Health Board with the aim of increasing online Friends and Family activity.

Patient Reported Outcomes Measures Survey: A questionnaire has been developed by the Patient Experience Department for Primary Care & Community who wanted to have a more Patient Reported Outcomes Measures Survey (PROMS) to use in their area. This has been designed however the Primary care team are now reviewing it before launching a test pilot site.



Patient stories: Ongoing work developing the ABMU Health Board Patient Stories SharePoint site. This site will house the library of patient stories which staff will have access too. Development of the Patient stories, Standard Operating Procedure, guide and toolkit has been developed to support the governance of this work and consistently across the Health Board

11. Claims

In addition to those cases settled under the Redress process, the Health Board continues to receive new Clinical Negligence and Personal Injury Compensation Claims. During the year 197 Clinical Negligence Claims were received compared to 187 claims received in 2016/17, 5% increase and 203 claims were received in 2015/16.

The Health Board also received a total number of 61 Personal Injury Claims in 2017/18 compared to 55 cases received in 2016/17 and 88 in 2015/16.

Some of the themes arising from Clinical Negligence and Personal Injury Claims include:

- Failure/insufficient monitoring of patient
- Failure/missed/delayed diagnosis
- Inappropriate aggressive behaviour to staff by patients
- Treatment/procedure incorrectly performed

11.1 Priorities for improvement (Claims Team)

The findings of the last Welsh Risk Pool Standard assessment completed in 2015/16 have been fully considered and an action plan developed to improve compliance against the Standard completed. During 2017/18 the following actions were taken to continuously improve the service provided:

- Claims Policy and Procedure updated.
- The Claims Team compiled a Handbook on the Regulations and Process of Redress for staff to ensure that they understand the Redress process.
- The Claims Team's Standard Operating Procedure Manual/Standard Operating Procedures for use within the Department to enhance training of staff within the Team and continuity in the management of claims, inquests and redress cases were reviewed.
- The Health Board delivered Well Being sessions for staff within the Patient Feedback Team to assist in coping with the nature of the work that is being dealt with on a daily basis.
- The Claims Team continue with Peer Reviews to provide support to staff and share complex cases with a view to sharing knowledge, learning and enhancing education and training.
- The Claims Team developed and continue to promote and foster good communication links with the SDUs.

- Lawtel following introduction into the team all staff have been trained which supports the review of case law and quantifying redress claims.
- Introduction pack developed for newly appointed staff has been reviewed and upheld.
- Internal Audit on Claims Management confirmed reasonable assurance with no actions identified (green rating).
- Serious Incident Training was provided to the Team.
- Action Plan training was provided to the Team.
- Training on quantifying cases was provided.

Actions to be achieved in 2018/19

- Training needs analysis to be undertaken for the Teams.
- Inquest training to be provided to the Claims Teams.

12. Inquests

The Health Board provided evidence of a total of 161 inquests during 2017/18. Four of these inquests resulted in the Coroner issuing a Regulation 28 Report, report to help prevent future deaths and promote learning/actions being taken. A summary of the four cases is provided below together with the actions taken to improve patient safety.

ID: 952

The Coroner issued the Regulation 28 report in relation to the following issues:

- Failure to monitor the patient neurologically
- Failure to act upon observation findings
- Failure to undertake observations in line with local and national guidance
- Lack of appropriate management of the nurse responsible for undertaking the observations

Action Plan/Actions Undertaken

The following have been incorporated into a formal action plan with clear timescales and responsibilities assigned to key individuals in undertaking and monitoring of the required actions as follows:

- Staff to be reminded of the need to adhere to the ABMU neurological guidelines Ward sister to reiterate to the nursing team on ABMU the Leadership and delegation responsibilities of the nurse in charge of each shift.
- For the month of October 2017 documentation to be reviewed (audit) on all patients who have sustained a fall on ABMU which will include compliance with neurological observations.
- Learning from the above audit to be shared with staff in ABMU and actions agreed for implementation.
- Outreach team are currently auditing NEWS compliance across all acute wards in a rolling programme.
- Training Needs Analysis (TNA) to be undertaken in relation to need for ALERT and Beach training in ABMU.
- Feedback from review of current Falls Policy and revised documentation currently on trial in Princess of Wales.
- Monitor this action plan monthly to ensure compliance and adherence to timescale.

In addition, the above actions will be reviewed by the Unit Nurse Director and Unit Medical Director and a summary report will be provided to the Quality and Patient Safety Committee in April 2018.

On the 10th March 2017 a Spot the Sick Patient Steering Group was sent up which meet up on a bi-monthly basis and one of the group's main focus is NEWS Observations. Please see the attached terms of reference. This will enable learning Health Board wide.

ID: 518

The Coroner issued a regulation 28 in relation to the Care plan review not being documented and that Nomad trays used to dispense medication may be unsuitable for some patients to use.

Actions taken to ensure that all care and treatment plans are reviewed in a timely manner:

1. A database has been developed with information relating to all Care and Treatment Plans (CTP) showing the review dates of all the plans and notifying the clinical and management team when that date is one month from the review date.
2. This database is sent weekly to the Community Mental Health Team (CMHT) manages for scrutiny and action. All CTP that are due within the month will

instigate an email from the manager requesting that the CTP be reviewed by the care coordinator and returned to the manager for sign off within the next 2 weeks.

3. If the CTP is not returned by the agreed date by the care coordinator the CMHT manager will arrange to meet with the care coordinator within the remaining 2 weeks to ensure that the CTP is reviewed and signed off prior to the expiration date.

Implementation:

- This has been implemented in all CTP's where the care coordinator is a health employee and discussions are being undertaken with the Social Services managers to get compliance across the multi-disciplinary team.
- If necessary CMHT managers will conduct a review of the compliance of all CTP's in care coordinators work load so that support can be offered and remedial actions implemented.
- If a patient is not available or does not wish to be involved in the review this will be recorded when the when the CTP is reviewed.
- It is recognised that not all CTP reviews will involve a medical colleague, where this occurs it will be recorded in the CTP review.

Actions taken to ensure that the effectiveness of the use of a nomad tray for the dispensing of medication for an individual patient:

Clinical teams have been reminded that were a patient is not managing their medication effectively the team should review the situation and consider all options to improve compliance with medication. These may include:

Support and counselling for the patient

- Advice and guidance from the patients pharmacist and GP
- Discussions with the patients family
- Daily prescriptions
- Involvement of the Assertive Outreach Team
- Admission to hospital

These discussions will take place within the normal risk management framework taking into consideration the risks identified and the use of least restrictive practices.

The Mental Health and Learning Disabilities SDU have reviewed these actions and believe that they will effectively address the risks identified in the Regulation 28: Report to Prevent Future Deaths. This learning was shared via the SDUs Quality and Safety Committee on 28th November 2017.

ID: 885

The Coroner issued a regulation 28 report in relation to the delay it took for an ambulance to reach the patient. The report was issued against Welsh Ambulance NHS Trust (WAST) for not re prioritising the call and joined the Health Board in the report on the basis that ambulances were delayed in leaving Emergency Departments. The Coroner recognised that this was a national issue.

Action taken:

- The Health Board provided the Coroner with a copy of the locally agreed procedure with WAST for the timely release of ambulances from the Emergency Department.
- The Coroner was notified that this was a priority of the Health Board which was monitored on a weekly basis and reported to the Executive Directors.
- Each Emergency Department also had local plans to improve the timeliness of the release of the ambulances from the Emergency Departments.

ID: 877

The Coroner issued a regulation 28 report to the Nursing Home the patient was being cared for in relation to the use of a catheter. The Coroner joined the Health Board in the notice to consider whether any further training could be provided to the Nursing Home.

The Coroner was advised that the Health Board provides a comprehensive training day in regard to urinary catheterisation for all Registered Health Care professionals employed by them.

The Health Board also offers this training to registered nurses within the nursing home setting, however they are not obliged to attend. The Health Board encourages providers to nominate staff to attend the various training sessions offered, unfortunately the Health Board is reliant on the provider being able to release staff to attend.

Since this incident a review has been undertaken. The Health Board have now implemented a booking and attendance system at community training which is to be recorded using an electronic central booking diary. This will ensure that accurate records are maintained of those who have attended training. It will also highlight areas where staff have not attended training.

Furthermore, where training for catheterisation was shared previously between all Continence Assessors, the Community Continence Service will now take responsibility for training community staff and secondary care will train staff in the secondary care

setting. This will allow the Continence Service to structure training to the environment staff are working in.

Training dates for catheterisation have been shared with Long Term Care Team to ensure the Health Board are able to monitor attendance from each care home. The Long Term Care Team work in partnership with Local Authority to monitor standards within the care home setting, part of this process is to review each care homes training register. Care homes that are not participating in training will be identified and monitored closely to improve compliance.

The Health Board's Nursing home assessors will receive training from the Community Continence Service regarding the management of urinary catheters including documentation. This will provide an opportunity for Health Board Nursing Home assessors to share good practice and to measure practice within the Care home setting against agreed standards of practice.

Good practice documentation was shared with the Long Term Care Team on the 31st October 2017 when the Community Continence Service and Long Term Care Team meet. This will include catheter bundles, patient urinary catheter passport for dissemination to Nursing/Care home staff. The care home sector are not currently using the above documentation in totality as the catheter passport is a new document which was recently introduced to the hospital & community setting and will now be extended to care homes.

Long Term Care Team will explore the feasibility of setting up a network of 'Continence Champions' where additional training could be provided by the Community Continence Service to cascade in all homes. Due to the large number of care home staff in the region the Health Board can offer a general level of continence training to care home staff, however, Continence Champions will be provided with a more intense programme of training to ensure they can support and advise their colleagues. Additionally, a continence e-learning link will be shared with Long Term care team for dissemination to Nursing/Care home staff.

Representative of Community Continence Service to attend the Care home providers meeting. All care homes in the region are represented in these meetings, the meeting allows care home managers and owners to receive updates and awareness sessions on relevant topics relating to health and social care. This is also an opportunity to share lessons learnt and good practice.

13. Learning Lessons

13.1 Learning Lessons/Actions Taken relating to Claims

Maternity – Resulting from a failure to correctly interpret and act on CTG tracings, the introduction of 'CTG Champions' and the work around the champions has promoted awareness and learning around antenatal CTG traces. The CTG Champions provide training to staff across the Health Board.

Consent – Legal & Risk Services have provided education to medical staff across the Health Board by delivering a presentation on the legal aspects of consent and the implications since the Montgomery case. This session is called 'the Grand Round' and has strongly been promoted by the Medical Director to all medical staff to attend. In addition, a publication of a guidance newsletter highlighting the implications of Montgomery and consent has been shared.

CVC lines and training – Following a serious incident which led to a claim, nurses are now required to undertake a competency training programme offered by the Health Board for the management and removal of CVC lines. The Competency training programme has been introduced and nurses in ABMU must be competency assessed before managing and removing CVC lines

Following the incorrect administration of Oromorph via the intravenous route, following the confusion of a flush and the oromorph, both of which were in syringes that looked identical, the unit moved to pre-packed clearly labelled flushes and the use of purple syringes for medications that are administered orally

Following a number of orthopaedic surgeries where the incorrect component or incompatible components had been inserted into the patient, a review was undertaken of the number of prosthetic joints available to surgeons. Following this review there has been a significant reduction in stock variance, ensuring that Consultant Surgeons are familiar with the reduced stock.

14. Next Steps

Within AMBU Health Board some improvement work being implemented in managing patient feedback mechanisms includes:

- **The Concerns and Redress Group**: will continue to meet monthly. The Group reviews a minimum of 10% of closed concerns/redress cases across the SDUs on a monthly basis and undertake deep dive reviews into Unit responses on a rotational basis. The Terms of Reference are currently being reviewed to consider including auditing Ombudsman action plans.

- **Concerns & Redress Workshops**: held in 2016/17 and 2017/18 for the SDUs facilitated by the Patient Experience, Risk & Legal Services Team which included; how to investigate and manage complaints ensuring compliance with the Concerns Regulations and values based responses, will continue in 2018/19

- **Training Needs Analysis** to be completed for Corporate and SDU staff who investigate and manage concerns and training plans updated as a result.

- The **Ombudsman Improvement Officer** – the Health Board will meet regularly with Officer to monitor and take action at the earliest stage in relation to improvements and learning from these concerns.

- **Workshop with the PALS and PEAS teams:** During June 2018 all the PALS/PEAS staff members and the Governance Managers attend a Corporate Workshop with Non Officer Member/Chair of the Quality and Safety Committee and Deputy Director of Nursing and Patient Experience. The workshop was an opportunity to recognise the excellent work the teams are doing across the hospitals and also establish priorities to take forward consistently across the Health Board. Future workshops are being planned.

- **Training:** Customer Care training with a clear focus on communication skills. In addition a pilot project has been proposed for working with staff who have a responsibility to deliver life changing news to both patients and their relatives. This training will also support *all other staff* working in an environment where life changing news has been given. This pilot is driven from a search of the data where patient/relatives felt they could have been better supported during such distressing circumstances. To achieve this the trainer will write bespoke sessions focusing on the need for sensitivity and the value dignity, empathy and compassion play in such situations. The trainer will use a variety of activities including role play and group discussion.

We will continue our commitment to work together with patients and their families to provide the best care possible for our patients and population, to truly reflect in our actions and achievements that ABMU cares as a listening and learning organisation.

15. Conclusions

The Health Board continues to make progress in the way concerns and claims are managed. However, we recognise that further work is required to continue to embed the changes made, ensure consistency across the Service Delivery Units and focus on continuous improvement and embed the learning.

A number of actions have been identified within the report to improve the management of concerns and claims within the Health Board. These actions underpin the main objective of the Patient Experience, Risk & Legal Services Team which is to deal with concerns timely and conduct robust investigations which produce recommendations, actions taken and the lessons learned shared across the Health Board to reduce the likelihood of harm to patients.

Appendix 1

Definitions

CLAIM	Legal perusal of action against a party to compensate for losses incurred.
CONCERN	A complaint, a notification of an incident concerning patient safety or a claim for compensation.
COMPLAINT	Any expression of dissatisfaction.
INCIDENT	Any unexpected or unintended incident, which did lead, or could have led to harm for a patient.
NON-OFFICER MEMEBER	A member of the Board who is not an employee of the Health Board.
OFFICER MEMBER	A member of the Board who is an employee of the Health Board.
PATIENT	The person who received or has received services from the Health Board.
PUBLIC SERVICES OMBUDSMAN FOR WALES	If a person raising a concern remains dissatisfied after raising a concern with a Health Board, they can request an independent review by the Public Services Ombudsman for Wales (PSOW).
PUTTING THINGS RIGHT	Guidance produced by Welsh Government for the NHS in Wales to enable health organisations to handle concerns in accordance with the NHS Redress Regulations.
REDRESS	Redress relates to situations where the patient may have been harmed and that harm was caused by the NHS in Wales. Redress can comprise of: ▪ a written apology; ▪ a report on the action which has or will be taken to prevent similar concerns arising; ▪ the giving of an explanation, and ▪ the offer of financial compensation and/or remedial treatment, on the proviso that the person will not seek to pursue the same through legal action.
QUALIFYING LIABILITY	Where a Welsh NHS body has BOTH (1) failed in its duty of care to a patient, and that the breach of duty of care has been (2) causative of the harm that the person has suffered. It is only when both these tests are satisfied that a payment of compensation under the NHS Redress Regulations should be considered.