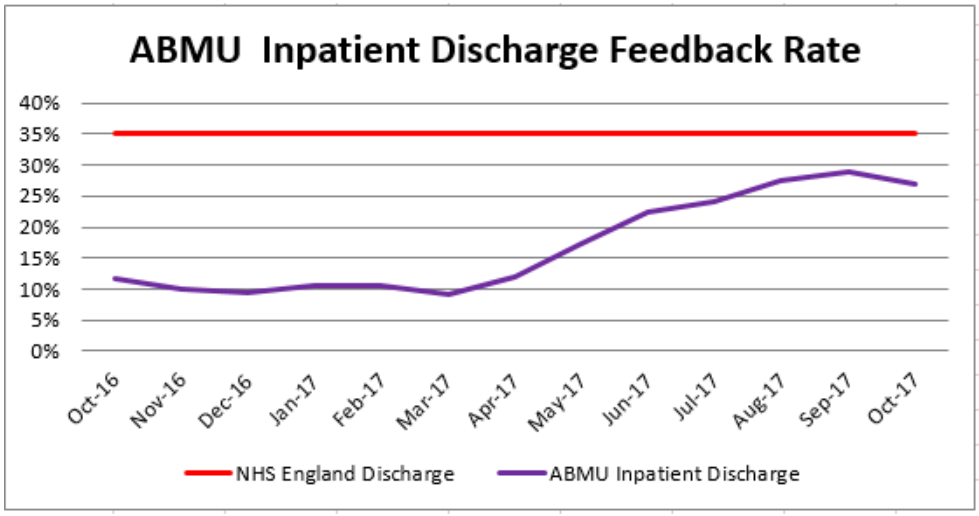
ABM University Health Board	
Date of Meeting: 1st February 2018 **Name of Meeting: Quality and Safety Committee** **Agenda item: 5.2**	
Subject	**Patient Experience Report**
Prepared by	**Hazel Lloyd, Head of Patient Experience, Risk & Legal Services**
Approved by	**Cathy Dowling, Deputy Director of Nursing & Patient Experience**
Presented by	**Angela Hopkins, Interim Director of Nursing & Patient Experience**

1. PROGRESS UPDATE – 'TOGETHER'

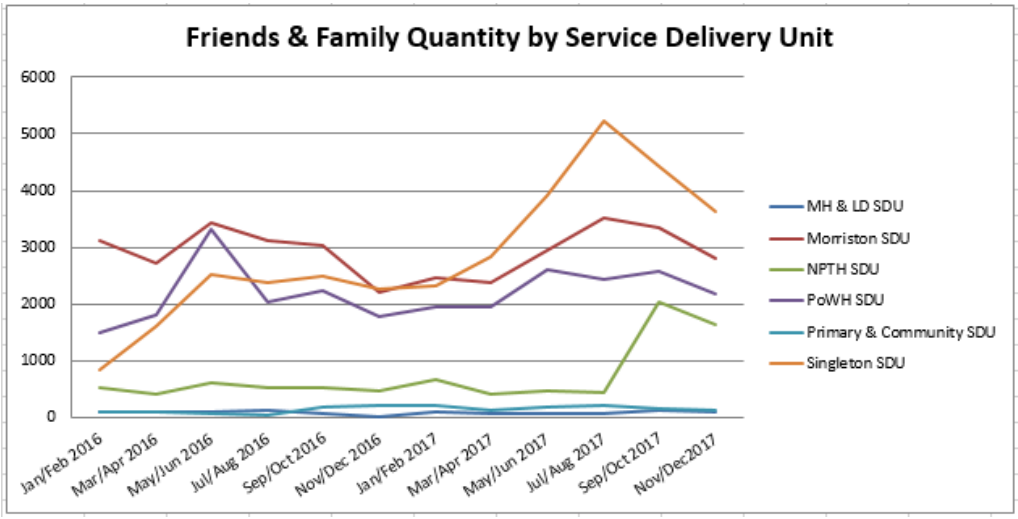
The Patient Experience Unit continues to provide support and guidance to the Service Delivery Units ("SDU") on increasing the number of surveys completed, and also offers patients the opportunity to give feedback.

The graph below indicates the discharge feedback rate benchmarked against the best performing Trusts for patient feedback returns in NHS England. The Health Board's performance in October was 27% which is slight decrease compared to 28.9% for September 2017.



	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
NHS England Discharge	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%
ABMU Inpatient Discharge	11.70%	10.10%	9.40%	10.70%	10.70%	9.20%	11.90%	17.20%	22.40%	24.10%	27.50%	28.90%	27.00%

The graph below shows the number of completed Friends & Family returns received by Unit:

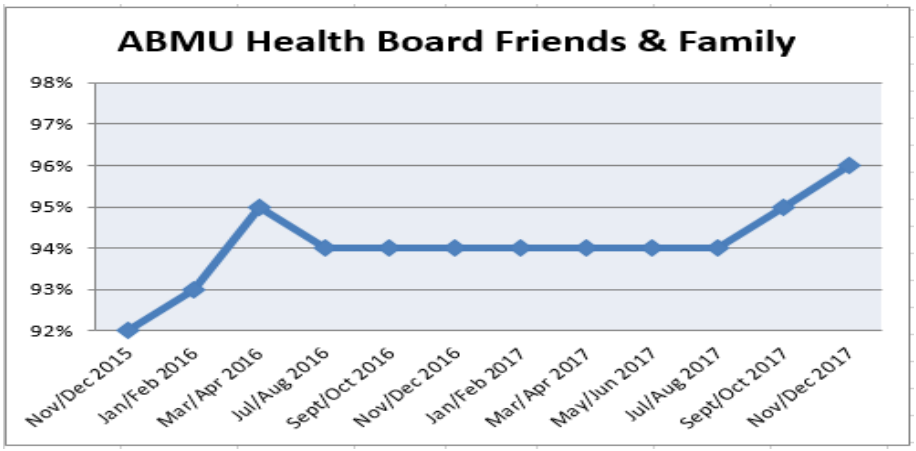


- There were 6,078 returns for November and the patient satisfaction score for November reached 96%, this is the second time this high score has been achieved. With the seasonal holidays in December the number of returns reduced (December 2016 and 2015 also saw a reduction in the number of returns) to 4,295, with an overall satisfaction rate of 95%.

- Creating a 5 star Patient Experience training continues and the trainer focuses on improving response rates to the F & F initiative but the importance of delivering care to set standards of behaviour. 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 with many areas seeing an increase in response rates. Therefore, 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.

- The Friends and Family and All Wales Surveys were used instead of the Fundamentals of care surveys (now named Health and Care Standards Annual Audit). The data collection took place from 1st October to 30th November 2017. The collection of these surveys has now closed and the change in approach did not lead to a spike in returns for this period.

The graph below shows the Health Board highly recommended score reached 95% in September/October 2017 and recorded the highest score for November/December at 96%.



Nov/Dec 2015	Jan/Feb 2016	Mar/Apr 2016	Jul/Aug 2016	Sept/Oct 2016	Nov/Dec 2016	Jan/Feb 2017	Mar/Apr 2017	May/Jun 2017	Jul/Aug 2017	Sept/Oct 2017	Nov/Dec 2017
92%	93%	95%	94%	94%	94%	94%	94%	94%	94%	95%	96%

The number of feedback forms completed for Friends and Family for September /October 12,512 and in November /December 10,379 which is a decrease of 2133 (17%) forms. The overall satisfaction score is 96% which is in line with National benchmarking for a second month.

2. BENCHMARKING – 'IMPROVING'

The tables below show the total eligibility similar to the Health Board for Trusts in England and the highly recommended scores for In-patients, Maternity and A&E for October 2017. The table indicates that the number of responses that would recommend the Health Board to Friends and Family for:

- In-patients has decreased from 95.43% in September to 94.63% in October 2017.
- A&E saw a decrease from 92.12% to 83.06%;
- Maternity saw an increase from 96.37% in September to 96.86% in October and;
- there has been a decrease in response rate performance for In-patients from 28.9% in September to 26.2% in October.

Inpatient October 2017

Trust Name	Total Responses	Total Eligible	Response Rate	Percentage Recommended	Percentage Not Recommended	Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't Know
England (excluding Independent Sector Providers)	226,762	912,514	24.9%	96%	2%	183,224	33,603	4,067	1,656	2,051	2,161
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	1,723	9,863	17.5%	97%	1%	1,451	220	22	14	10	6
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	1,906	9,749	19.6%	95%	2%	1,513	305	32	17	24	15
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	1,938	10,200	19.0%	95%	2%	1,489	359	41	20	17	12
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	1,691	9,314	18.2%	97%	1%	1,487	152	26	7	9	10
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	708	9,624	7.4%	95%	1%	546	130	20	6	4	2
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	5,615	17,251	32.5%	97%	1%	4,736	684	76	49	22	48
ABMU Health Board	2,572	9,822	26.2%	95%	2%	2,081	353	56	15	27	16

Maternity October 2017

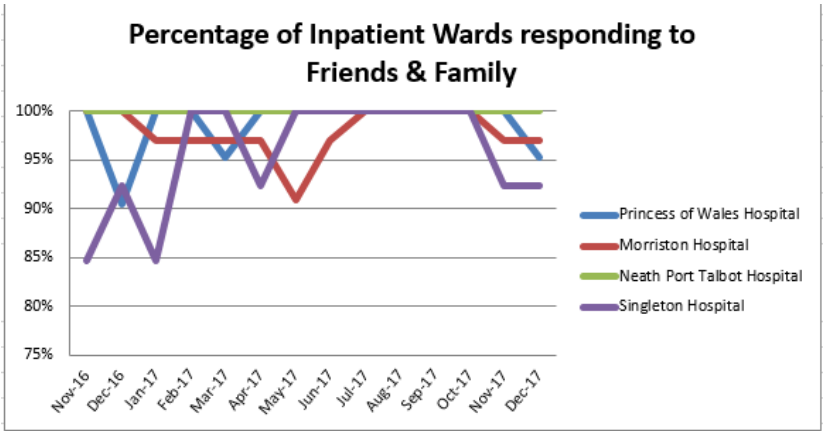
Trust Name	Total Responses	Total Eligible	Response Rate	Percentage Recommended	Percentage Not Recommended	Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't Know
England (excluding Independent Sector providers)	12,137	52,087	23.3%	96%	2%	9,693	1,998	170	93	90	93
PORTSMOUTH HOSPITALS NHS TRUST	126	445	28%	98%	1%	108	16	1	0	1	0
MID YORKSHIRE HOSPITALS NHS TRUST	132	532	25%	100%	0%	114	18	0	0	0	0
NORTH BRISTOL NHS TRUST	60	488	12%	85%	12%	41	10	2	2	5	0
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	71	521	14%	99%	0%	66	4	0	0	0	1
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION T	97	617	16%	98%	0%	78	17	2	0	0	0
BOLTON NHS FOUNDATION TRUST	98	535	18%	96%	3%	85	9	1	1	2	0
ABMU Health Board	287	528	54%	97%	1%	235	43	4	2	1	2

A&E October 2017

Trust Name	Total Responses	Total Eligible	Response Rate	Percentage Recommended	Percentage Not Recommended	Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't Know
England	138,135	1,089,747	12.7%	87%	7%	91,783	27,798	6,136	3,972	6,193	2,253
HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	1,054	9,461	11.1%	86%	9%	729	174	38	35	55	23
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	818	8,898	9.2%	80%	12%	468	183	61	35	62	9
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	315	9,480	3.3%	91%	6%	236	51	8	3	16	1
NORTH WEST ANGLIA NHS FOUNDATION TRUST	547	9,339	5.9%	95%	2%	391	130	9	6	5	6
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	1,641	9,048	18.1%	89%	3%	1,048	411	83	20	32	47
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	1,064	9,172	11.6%	86%	7%	742	168	46	35	42	31
ABMU Health Board	317	Unavailable	Unavailable	83%	3%	154	111	12	19	9	11

The table below demonstrates the number of ward areas providing feedback from each of the four main hospital sites. The table indicates that Neath Port Talbot Hospital continues to return 100% feedback since September 2016. The Princess of Wales Hospital remained consistent at 100% from April through to October 2017. Although in December 2017 their return rate decreased to 95% which is consistent with December 2016 where they also decreased to 90%. There is a year on year trend showing the response rate in December decreases across the hospitals. The exception is NPT SDU where they have held the 100% response rate.

The SDU's aim is to increase feedback to 100% compliance for each hospital and sustain this response rate throughout the year.



Percentage of Inpatient Wards responding to Friends & Family

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Princess of Wales Hospital	100%	90%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	95%
Morriston Hospital	100%	100%	97%	97%	97%	97%	91%	97%	100%	100%	100%	100%	97%	97%
Neath Port Talbot Hospital	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Singleton Hospital	85%	92%	85%	100%	100%	92%	100%	100%	100%	100%	100%	100%	92%	92%

Total Inpatient Wards	No. of Wards on Site	Wards with no reply for November 2017
Princess of Wales Hospital	21	0
Morriston Hospital	33	1
Neath Port Talbot Hospital	6	1
Singleton Hospital	13	1

Total Inpatient Wards	No. of Wards on Site	Wards with no reply for December 2017
Princess of Wales Hospital	21	1
Morriston Hospital	33	1
Neath Port Talbot Hospital	6	0
Singleton Hospital	13	1

3. 15 STEP CHALLENGE

A 15 Step Challenge visit was undertaken on Ward R at the Morriston Hospital on 15th December 2017 as the ward had been reported to the Committee as a Hotspot ward in December 2017.

The purpose of the visit was to understand what good quality care looks and feels like from a patient's and relative's perspective. The report is attached as **Appendix 1.**

There were a number of issues identified during the visit and action points included:

- Patient reported medication error.
- Non- compliant member of staff with medicines administration policy (signing for medication before meds being taken)
- Drugs key found in cupboard of medication room (Main door to room locked).
- Pain management – Patient report poor experience of pain management. Staff also highlight this as an issue.
- Discharge Planning - Poor documentation around discharge planning. This was also highlighted on the assurance visit last year.
- Communication **–** Most of the negative feedback reported in the patient feedback section relates to poor communication between staff and patients. This issue was not just related ward nursing staff. For example, one patient had been on the ward for three weeks and had their operation cancelled ten times. Another patient reported receiving information from one Doctor which had not been handed over to staff.
- Non-compliant staff with uniform policy.
- Doctors not compliant with bare below the elbow and dress code policy.
- Non-compliant member of staff with the correct procedure to dispose of PPE.
- Ward is cluttered with cleaning trolleys, linen trolley and equipment in walkways. Due to limited storage and need to provide more equipment & mobility aids needed due to nature of patients, this is a daily risk for ward.

Immediate feedback was provided to the Ward Manager on day of visit. The Unit Nurse Director was also given feedback on good practice observed and concerns. The full report has been presented to the Unit Nurse Director and Ward Manager. These actions have been put into an action plan with timescales and are being monitored by Morriston Hospital Delivery Unit's Quality and Safety Group.

A 15 Step Challenge visit was undertaken to Cwmavon Health Centre, Port Talbot on 11th January 2018

General comments:

The centre is located in the middle of a housing estate and consists of a solid, well kept building originally built in the early 1970`s. The service has recently merged (April 2016) with a practice

located further up the Afan Valley in Cymmer and now provides a service to approximately 6,000 patients. The practice has already implemented many changes to the original service provided to the local community, including a triage telephone service, nurse led minor illness clinics and a practice based pharmacist. There was evidence of user engagement and it is recognized that both the community and the practice staff found this challenging but there have been successes with some work identified as still to do. The environment is generally fit for purpose and is well kept and clean. The enthusiastic centre team understood the local community and were able to give a good account of what they aimed to achieve over the next few years.

WELCOMING:

Entry to the building is via a wide, low silled doorway easily accessible to patients with mobility problems. The reception space is a large, well lit area with good signposting, posters refer to the issue of privacy and ask people to stand away from the desk if someone is already being seen. The centre is shared with an independent practice which has a separate reception desk and shared accommodation. There is a good amount of current information for patients on various health issues and health promotion initiatives, the centre was promoting the `Flu` vaccine campaign with bunting and leaflets clearly visible.

Action required	How, By Who and When?
Consider using boards to display themed information.	Centre Manager, September 2018
Plans underway to clear clutter within reception area, notes possibly being moved to off site location for storage.	Practice Manager September 2018

SAFE:

The centre is located in the middle of residential houses and is surrounded by a security fence. The staff report no security issues, they are aware of lone worker issues and were able to describe procedures to be taken if concerns were evident. Equipment was stored appropriately and the corridors were free from clutter. The building was clean and was in good repair. The staff related some issues with poor lighting in the car park in winter but this isn't currently affecting the quality of the service provided.

Action required	How, By Who and When?
Secure funding to improve lighting (low priority)	Practice Manager

CARING AND INVOLVING:

The staff were extremely enthusiastic about the services the centre provides and there was a strong sense of teamwork. All the staff we spoke with were committed to the changes being made and there

was clear direction and a sense of how the staff saw the centre improving services in the next few years. The centre team also mentioned that they felt they were fully engaged in the potential redesign of the building.

Staff told us there had been a number of patient engagement events which were poorly attended and they are finding the issue of patient consultation and engagement a continuing challenge. The centre has a suggestion box with poor uptake from the patients using the centre. There has been some uptake with the use of an Ipad to collect feedback using the Friends and Family surveys. There are plans to display performance information such as average time to seeing or talking with a health professional, average time to answer phones, patient satisfaction feedback etc. There is little uptake of the `My Health Online` system.

The team has developed a Patient Survey specific to their user group. This has been circulated for discussion and is part of the engagement strategy.

Action required	How, By Who and When?
To improve levels of patient feedback.	Apply to Charitable funds to purchase another Ipad. Consider alternative ways of engaging with patients, consider best practice elsewhere. Aim for improvement by September 2018.
To display performance related information in public areas.	Centre staff to agree quality measures, use boards or existing display areas to display information. Aim for implementation by September 2018.
Finalise and implement Patient Survey and display results. Action Plan development where necessary.	Centre staff to aim for implementation and action planning by September 2018.

WELL ORGANISED AND CALM:

As mentioned previously, the centre has a team of enthusiastic staff who are fully engaged with the service changes that are being made. During the 15 Steps visit we were accompanied by the Clinical Director, a Senior Nurse, the Service Manager and the Practice Manager, all of whom were able to describe the service changes undertaken and those that are planned. The team were able to describe their roles and how they fit into the day-to-day business of the practice. The team described how they ulitise the rooms available and are looking to further develop the use of the centre, this requires some investment in infrastructure (IT points) and redesign of some key rooms (treatment room which was divided into two rooms needs to revert to one large room) to be able to offer more services to the community, such as minor operations etc. Possible funding streams are already being explored.

Conclusion:

It should be noted that the visit was conducted using standard 15 Steps methodology as a guide. The headings for feedback were used for consistency but the approach required to visit these types of units needs to be refined and we would welcome the opportunity to shape this revised methodology.

We would like to thank the staff for their welcome on the day of the visit and for sharing their obvious enthusiasm for the work undertaken and the work yet to do. We would like to revisit the centre in 8 months time to see how plans are progressing.

PRESSURE ULCER HOTSPOTS

For the months November and December 2017, 45 suspected deep tissue/ depth unknown pressure ulcers were reported across the Health Board and of these 19 were in the community. Twenty were reported in November, and a further 25 in December 2017.

	MHLDs		Morriston Hospital SDU		NPTH SDU		P&C Services		POWH SDU		Singleton Hospital SDU	
Severity	Nov 17	Dec 17	Nov 17	Dec 17	Nov 17	Dec 17	Nov 17	Dec 17	Nov 17	Dec 17	Nov 17	Dec 17
Suspected Deep Tissue/Unknown	1	0	4	7	0	0	8	11	5	6	2	1
Grade 3	0	0	0	0	0	0	3	2	1	2	0	0
Grade 4	0	0	0	0	0	0	1	2	0	0	0	0
Unstageable	1	0	1	1	0	0	4	4	2	2	2	0

Hotspot wards:

Morriston General ITU – x 3 (x 1 Nov, x 2 Dec – All suspected deep tissue/ unknown)
Morriston AMAU West – x 2 (x 2 December Suspected deep tissue/ unknown)
Morriston Ward J – x 2 Dec (1 x Suspected deep tissue/ Unknown, 1 x Unstageable)

POWH Ward 10 – x 2 (x 1 Nov Unstageable, x 1 Dec suspected deep tissue/ Unknown)
POWH Ward 4 – x 2 (x 1 Nov Unstageable, x 1 Nov suspected deep tissue/Unknown)
POWH Ward 8 - x 2 (x 2 Nov suspected deep tissue/ Unknown)
POWH Ward 7 - x 2 (x 1 Nov, x 1 Dec, both suspected deep tissue/Unknown)
POWH Ward 18 – x 2 (x 2 suspected deep tissue/Unknown)
POWH AMAU - x 3 (1 x Nov, 2 x Dec - All Grade 3)

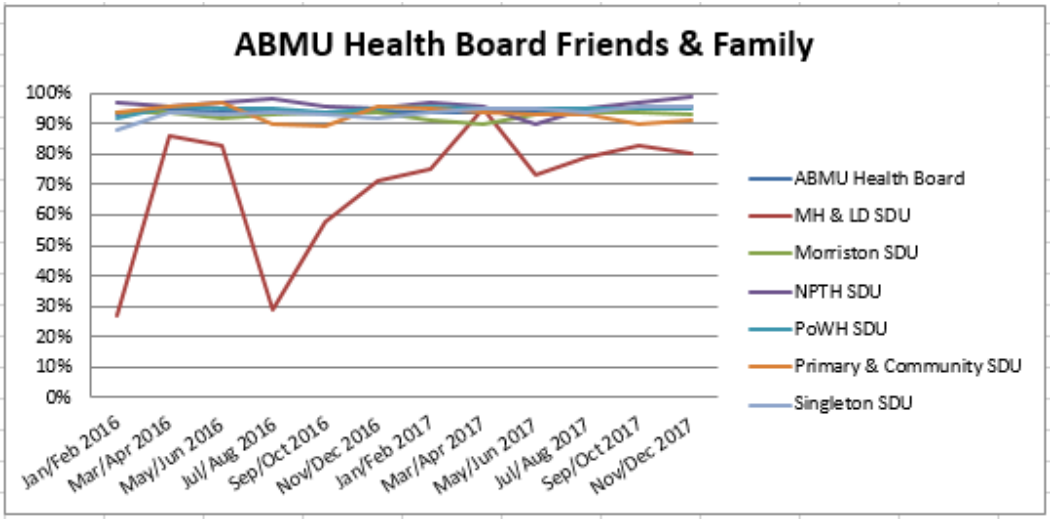
Singleton SAU – x 2 (x 1 Nov suspected deep tissue/ Unknown, x 1 Dec Unstageable)

4. CARING

This section provides an update on the work of the Patient Experience Department, which aligns with the work plan 2016-2018. The Department is providing support and guidance to the SDU's on increasing the number of Friends & Family completed to reach the 35% target for feedback from the number of discharged/patient flow. This is being performance managed through the SDU's performance management framework. The returns are important as feedback provides a `thermometer` for the SDU's to gage the quality of the care and treatment they provide to patients and families.

The graph below shows the percentage of positive responses i.e. responses in relation to whether people who completed the Friends and Family survey would recommend the service to others needing similar care and treatment. The Friends and Family reports are now available in Welsh to be displayed weekly alongside the English report and the Hospital reports are published on the internet site in Welsh.

The graph below sets out the Friends & Family % response rate by Service Delivery Unit's.



	Nov/Dec 2015	Jan/Feb 2016	Mar/Apr 2016	May/Jun 2016	Jul/Aug 2016	Sep/Oct 2016	Nov/Dec 2016	Jan/Feb 2017	Mar/Apr 2017	May/Jun 2017	Jul/Aug 2017	Sep/Oct 2017	Nov/Dec 2017
ABMU Health Board	92%	93%	95%	94%	94%	94%	94%	94%	94%	94%	94%	95%	96%
MH & LD SDU	76%	27%	86%	83%	29%	58%	71%	75%	95%	73%	79%	83%	80%
Morriston SDU	95%	94%	94%	92%	93%	94%	94%	91%	90%	93%	94%	94%	93%
NPTH SDU	96%	97%	96%	97%	98%	96%	95%	97%	96%	90%	95%	97%	99%
PoWH SDU	95%	92%	96%	95%	95%	94%	95%	96%	95%	95%	95%	95%	95%
Primary & Community SDU	81%	94%	96%	97%	90%	89%	96%	95%	94%	93%	93%	90%	91%
Singleton SDU	91%	88%	94%	93%	94%	93%	92%	94%	95%	95%	94%	96%	96%

	Nov/Dec 2015	Jan/Feb 2016	Mar/Apr 2016	May/Jun 2016	Jul/Aug 2016	Sep/Oct 2016	Nov/Dec 2016	Jan/Feb 2017	Mar/Apr 2017	May/Jun 2017	Jul/Aug 2017	Sep/Oct 2017	Nov/Dec2017
MH & LD SDU	33	85	96	106	112	67	21	84	58	52	58	112	84
Morriston SDU	2352	3127	2718	3431	3106	3021	2215	2468	2375	2957	3508	3350	2805
NPTH SDU	225	508	409	606	518	510	459	664	404	476	441	2026	1641
PoWH SDU	1350	1496	1804	3312	2020	2230	1791	1950	1962	2599	2433	2574	2185
Primary & Community SDU	72	108	85	75	41	190	214	222	109	171	218	141	132
Singleton SDU	819	845	1602	2517	2376	2476	2267	2320	2843	3904	5235	4421	3616
			6618	9941	8061	8427	6946	7624	7693	10107	11835	12512	10379

The Friends & Family responses decreased during November/December 2017 to 10,379 which is a decrease of 2133 (17%) forms when compared to September/October 2017. The overall satisfaction

score reached 96% for the first time (combining both months data range). There were 8,575 responses to the Planned Care Friends and Family test in November/December 2017, which is a decrease of 1,424 responses (14%) of the 9,999 reported for September/October 2017. Of the 8,575, 96% of the respondents were likely to recommend the ward/areas they visited to others who needed similar care, which is the same as the 96% across the Health Board as a whole.

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

- The Patient Experience Team held a further meeting with Primary Care, on the 20th December to support the roll out of Family and Friends. A redrafted survey form is being consulted on within the Unit. The Patient Experience Team will meet with heads of Primary Care, GP, Dentist, Opticians, Pharmacy to discuss any further changes required. The Health Board PROMS/PREMS Clinical Lead is supporting this work. A redrafted survey form is now being consulted on within the Unit.

- A pilot on the use of Ipads in five areas in the Health Board to collect patient experience surveys has been completed. Prior to evaluation the pilot is being extended to Maternity and NPT SDU. A meeting has been arranged for February with Unit Nurse Directors to discuss the next steps.

- The Patient Experience Team (PET) are working with the Modernisation Group to explore the use of SMS Texting to gain retrospective feedback for Friends and Family from service users. ABM IT Department and PET meet in January to review progress with the aim of setting this service up in quarter four of 2017/18.

- The Snap Patient Feedback System and ABM IT Department are working together to set up self-reading system for the Friends & Family cards. This process will require the free text to be keyed, but all other data captured will be populated from the software. The aim is to test the system in quarter four of 2017/18.

- Patient Experience Team attended the National Cancer meeting in Cardiff. The meeting was an excellent platform for information sharing. Welsh Government, Macmillan and Maggies centre staff were extremely excited to hear about the cancer patient feedback ABM captures weekly. The reports generated were shared and a further development meeting has been arranged in January 2018 with ABM Cancer Leads to discuss how to use the feedback and make improvements using the patient experience captured.

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

- Labour Ward, Princess of Wales Hospital (123 responses)
- Fracture Clinic, Morriston Hospital (244 responses)
- Elderly Day Hospital, Neath Port Talbot Hospital (61 responses)
- Surgical Day Unit, Singleton Hospital (232 responses)

Some of the lower scoring areas for the reporting period included:

- Main OPD, Morriston Hospital (72%)
- Ward 08, Princess of Wales Hospital (76%)
- Phlebotomy, Singleton Hospital (33%) **Only 3 responses*

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

- Appointments running late and parking issues.
- Long waiting times on ward, more staff required (ongoing theme)
- Staffing issues and parking issues (ongoing theme)

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

`Lets Talk`

From the end of June 2017 ABM Let's Talk transferred to the Patient Feedback Team to manage. The Datix 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, November & December there were 32 contacts made by members of the public 15 converted into complaints for the SDU's.

'Patient Opinion' is now called 'Care Opinion'

ABM Health Board has subscribed to be able to respond to comments made on the Patient Opinion website. There were no comments posted on the site for November or December 2017.

You Said We Did

YOU SAID **Ward 6, Singleton**: Patient's family got in touch with PALS as they were unhappy with their relative's treatment and staff attitude on the ward and the patient who was end of life was very upset.	**YOU SAID** **Ward V, Morriston**: There weren't enough hand rails on one of Ward V's showers, leaving the patient feeling unsafe taking his post op shower.
WE DID PALS spoke with the family and arranged for a meeting with the Matron of the ward. Meeting took place and the family were very happy with the outcome and felt a lot more assured with the care.	**WE DID** There is a hand rail in situ as well as a shower chair. The Ward Manager has requested the Estates Department review to see if another hand rail can be fitted for extra reassurance.

YOU SAID **Atrium, NPTH:** More information to be available in the main Atrium regarding	**YOU SAID** **Outpatients Department, POWH**: Patient completed Family and Friends feedback about

support services for cancer.		waiting time for appointment**.** When contacted the patient advised that the doctor delivered a diagnosis of cancer of the lung.
WE DID Linked in with Macmillan to enquire about the availability of a pod unit based in Neath Port Talbot Hospital (now agreed). Patients will be able to talk in private to Macmillan workers who can offer advice and support.		**WE DID** Apology provided to patient and assurance that the issue would be investigated and dealt with. Patient grateful to receive call and be able to provide feedback on how diagnosis was delivered. The Lung Cancer Nurse Specialists at Princess of Wales Hospital, Bridgend have set up a support group for those with a diagnosis of lung cancer, along with their relatives and carers. Aim to provide a friendly and supportive environment where you can come along and meet others in a similar situation to share experiences and advice.

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

Percentage of patients that ticked 'Always' to the following questions:													
Treated with Dignity?													
Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
97%	96%	93%	97%	95%	95%	94%	95%	95%	95%	96%	95%	92%	95%

You were given help with feeding & drinking?													
Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
63%	78%	74%	87%	75%	84%	79%	72%	79%	82%	73%	85%	85%	86%

Were you given the support you needed to help with any communication needs?													
Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
91%	89%	88%	92%	90%	92%	91%	88%	86%	89%	91%	90%	91%	87%

Were things explained to you in a way that you could understand?													
Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
89%	88%	83%	89%	88%	87%	87%	86%	83%	85%	89%	87%	86%	88%

Did you feel we did enough to keep you as free as possible from pain?													
Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
91%	87%	83%	86%	85%	84%	87%	83%	85%	87%	88%	86%	81%	94%

People are kind and compassionate to you?													
Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
88%	90%	88%	89%	89%	89%	89%	88%	86%	91%	91%	88%	94%	92%

People are welcoming, friendly and helpful?													
Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
89%	92%	91%	88%	89%	89%	88%	91%	84%	91%	90%	88%	91%	86%

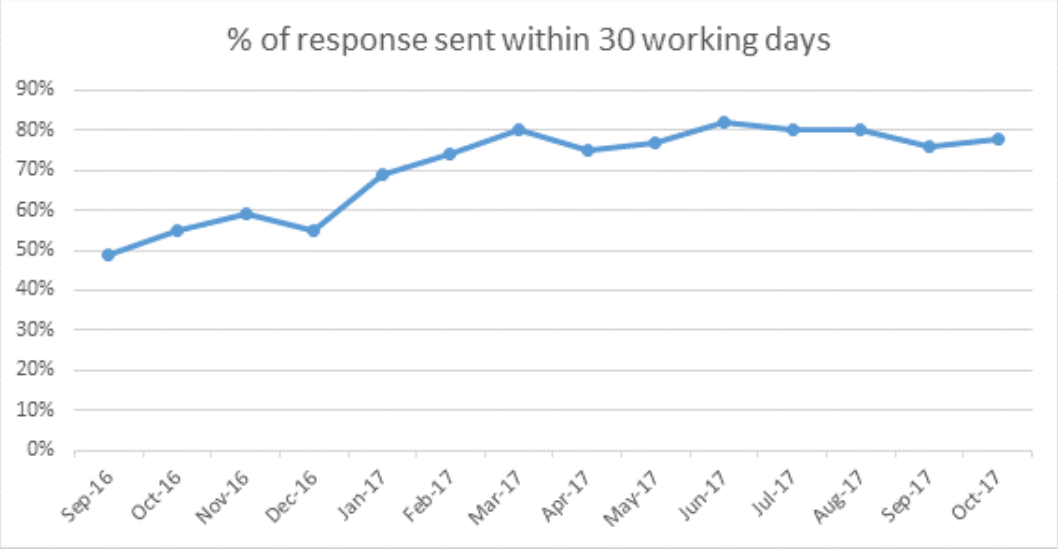
Percentage of patients that ticked 'Never' to the following question:													
At any point in your stay did any of our actions make you feel unsafe?													
Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
92%	92%	87%	91%	90%	87%	83%	90%	90%	90%	91%	91%	85%	89%

Concerns Performance and Action from Feedback

The performance chart demonstrates an increase in performance for October 2017, 78%, when compared to October 2016, 55%, for the percentage of responses sent within 30 working days. The Health Board achieved Welsh Government's target of 75% for this measure, although did not achieve the Health Board's internal target of 80%.

Princess of Wales is the lowest performing Unit with 67% for 30 day responses. The Unit Nurse Director and Governance Team have been alerted and this issue will be discussed at the Unit's performance review with Executive Directors to seek assurances on improvements in the response rate.

The Deputy Director of Nursing & Patient Experience is continuing to hold performance meetings with the SDU Directors to monitor trends and challenge the 30 day response rate for SDU's as well as the quality of responses.

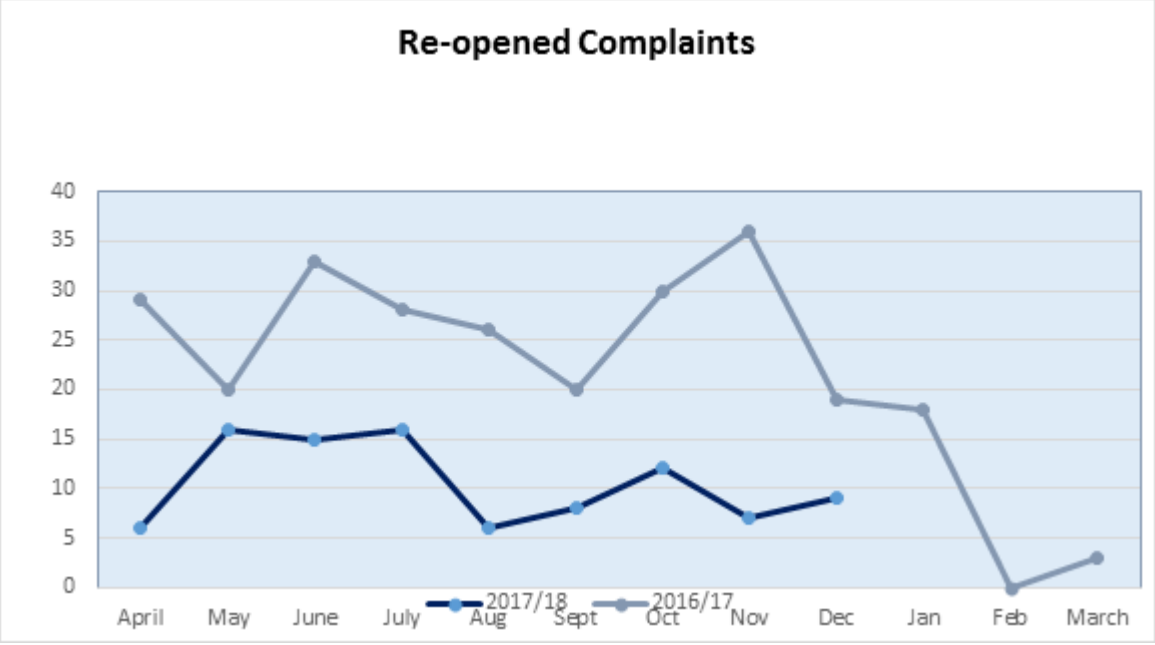


Monthly audits are continuing on closed SDU's complaint responses through the work of the Concerns, Redress and Assurance Group for Regulation 24 and 26 responses. The audits monitor quality and compliance with Health Board Values, and Putting Things Right Regulations. Feedback on the audits is reported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

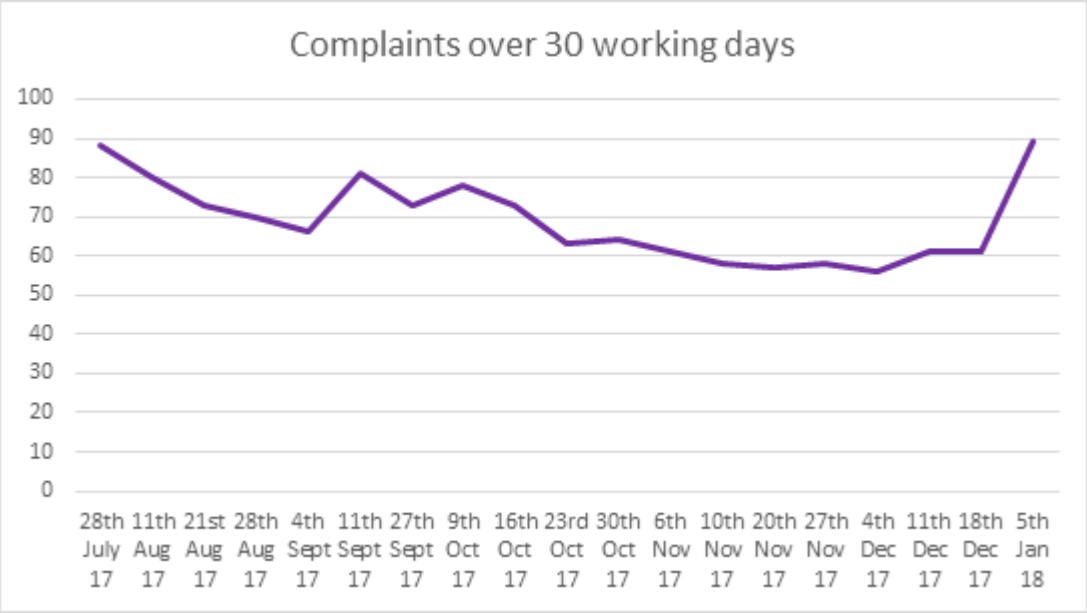
The Health Board is maintaining a 100% target performance of acknowledgement letters within 2 working days.

The staff within the Units are continually improving their complaints processes with the aim of consistently achieving the 80% target of sending a response to complainants within 30 working days while ensuring the quality of the investigations and responses sent is appropriate.

	Number Received	Number Acknow-ledged within 2 working days	% Acknow-ledged within 2 working days	Number of Responses sent within 30 working days	% of Responses sent within 30 working days	Number of Responses sent in over 30 working days	Re-opened
EMRTS	1	1	100%	1	100%	0	0
Corporate Medical Director (Including IT,Health Records)	1	1	100%	0	0%	1	0
Mental Health and Learning Disabilities Delivery Unit	8	8	100%	7	88%	0	0
Morriston Hospital Service Delivery Unit	43	43	100%	37	86%	0	0
Neath Port Talbot Hospital Service Delivery Unit	6	6	100%	6	100%	0	0
Planning	1	1	100%	1	100%	0	0
Princess of Wales Hospital Service Delivery Unit	24	24	100%	15	63%	4	0
Primary and Community Services	14	14	100%	11	79%	0	0
Singleton Hospital Service Delivery Unit	28	28	100%	22	79%	0	0
Totals:	126	126	100%	100	79%	5	0



Since the timeliness of responses has improved, the number of reopened cases has decreased and the graph above sets out the position for 2016/17 and 2017/18.



The graph above demonstrates the complaints awaiting a first response over 30 working days. There is a weekly review of long standing overdue complex complaints. There are currently 89 cases outstanding, 6 of which are over the desired six month target.

Maintaining the Health Board target of responding to 80% of complaints within 30 days has influenced the Health Boards ability to reduce the longest waiting complaints. In October, the 30 day response rate achieved was 78% and this is reflected in the increase in complaints in the graph above.

A plan is in place to actively reduce these monitored by the Deputy Director of Nursing and Patient Experience.

Key performance Indicators

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 November/December has improved to 96% this is the first time the combined data has reached this score. Below are the hospital site scores: Gorseinon Hospital 79% (84%), Maesteg 100% (96%), Morriston Hospital 94% (94%), Neath Port Talbot 98% (97%), Princess of Wales Hospital 95% (95%) and Singleton Hospital 96% (96%). NPTH and Maesteg have improved from the last reporting period in brackets; Morriston, POWH and Singleton have remained the same. Gorseinon has dropped 5% for this reporting period.
Retrospective – more in-depth surveys	The overall satisfaction score from feedback of the Patient Experience Framework questionnaire has slightly dropped 1% to 84% This is based on the number of people scoring 9 and 10 from a scale of 0 to 10.
Balancing – Concerns,	Mental Health and Learning Disabilities delivered a patient story to the Board

Patient Stories	in December 2017. Title of the story: Michelle's Story. How staff helped Michelle learn coping strategies and value herself.
Proactive/Reactive – texts, social media	48 alerts were received into the Patient Experience inbox for November and December of which 11 needed to be escalated to the PAL's Team or Governance Manager for the area. The ABMU Let's Talk mailbox received 32 feedback e-mails for November and December which were forwarded to the appropriate teams.

Arts in Health Update

The following 3 projects are due to commence:

Dance to Health
Falls are the commonest cause of serious injury in older people and the most frequently found reason for hospital attendance. One in three people aged over 65, and half of those aged over 80, fall at least once a year (Todd and Skelton 2004). Falls are the commonest cause of death from injury in the over 65s, and many falls result in fractures and/or head injuries. Falls cost the NHS more than £2 billion per year and also have a knock-on effect on productivity costs in terms of carer time and absence from work (Snooks *et al* 2011).

Falls prevention exercise has been proven to be extremely effective in reducing falls. It plays an important role in the falls care pathway, both in terms of primary and secondary prevention, and can significantly contribute to reducing the financial burden on the NHS and social care by preventing fractures and avoidable hospital admissions.

Arts Enterprise with a Social Purpose (AeSOP) is an arts charity and social enterprise based in Oxford. They ran a successful Dance to Health pilot project from February 2015 to July 2016. The charity subsequently raised £2.3million to scale up the programme across the UK.
ABMU Health Board is identified as one of the Health Partners for the Phase 1 roll out and has the unique opportunity of being the only Health Board in Wales who is involved in the scheme. The dance partner is the National Dance Company Wales.

ABMU Arts team have contributed £30K towards the project. The return on this investment is estimated at upwards of £200K. The patients will each have a treatment programme for six months and then transfer into maintenance groups. There will be four treatment groups of 20 people each and two groups of 12 people The group size follows the evidence based recommendations and will provide falls protection for a total of 104 people over two years.
Groups begin this month in Gorseinon, Pontardullais, Ystralyfera and Port Talbot

Storytelling in Mental Health

An experienced forensic mental health nurse who works for Elysium Healthcare in south East Wales has been seconded to work at ABMU on an honorary contract one day a week to pioneer work as a clinical nurse specialist in storytelling.

She starts work this month these are her Aims and Objectives:

- Overarching Aim - to develop new thinking and evidence based learning about storytelling and mental health that becomes recognised and adopted as good practice within health services
- Goal 1 - to have a positive impact on supporting people's mental health in the community
- Objectives: to run a monthly storytelling for wellbeing cafe in Swansea
- To support a weekly women's storytelling/creative group in a community setting in the Bridgend/Neath Port Talbot area.
- To develop a reflective evaluation process for the cafe and the women's group
- Goal 2 - to aid recovery through developing authentic nurse/patient relationships informed by storytelling skills
- Objectives: to develop a pool of confident nurse storytellers who can use storytelling with patients and patient groups
- To develop a reflective evaluation process for the storytelling inpatient work
- To work with the University of South Wales to develop an accredited course for training health practitioners to become storytellers
- Goal 3 - to share our learning through presentations, posters, conferences and publications
- Objectives: to present regularly at meetings within ABMU Health Board and Elysium Healthcare
- To present the work nationally and internationally
- To write at least one paper for publication

Performing Medicine and staff resilience

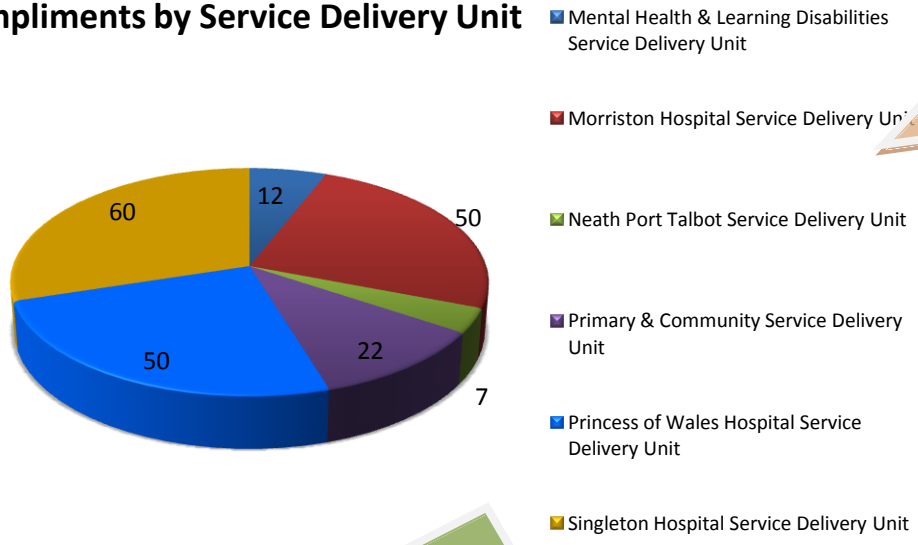
Performing Medicine's unique approach is delivered by leading artists using techniques and ideas drawn from theatre, dance and fine arts. They create supportive, safe environments where participants can rehearse the skills and behaviours necessary to thrive as healthcare professionals. Through practical exercises and lateral learning techniques, they nurture the flexibility, adaptability and responsiveness required to provide high-quality person-centred care. The Point of Care Foundation's 2014 report also puts the case that supporting staff should be a central driver in efforts to improve patient care, productivity and financial performance. It highlights that:

- Patient satisfaction is consistently higher where there are better rates of staff health and wellbeing
- There is a link between higher staff satisfaction and lower rates of mortality and hospital-acquired infection
- The NHS could save £555 million a year if it reduced sickness absence by a third
- Approximately 30% of sickness absence in the NHS is due to mental health illness (ABMU 31% August 2017 and increasing month on month)

The Arts in Health Team have secured a small grant from Arts Council Wales to run a series of scoping meetings, taster sessions and awareness raising presentations in spring 2018 which will lay the groundwork for a pilot project of arts based education with healthcare staff in ABMU's Mental Health and Learning Disabilities delivery unit.

Compliments – November/December 2017

Compliments by Service Delivery Unit



Ward G Morriston:

"I'd like to thank the surgeon, ICU, Ward G, the whole team from the bottom of my heart for giving my dad a chance, for taking care of him, for taking care of my mum and for the support they also gave us as a family!! Thank you doesn't even touch how thankful we are, everyday my dad does something that amazes us after the surgery he has undergone and without the chance for the surgery who knows what the outcome would have been. It's still a tough and uncertain time ahead but the whole team gave him the chance to beat cancer. My parents are my heartbeat and I am eternally grateful for you taking care of him!!!"

Paediatric Assessment Unit and Ward M:
"My Son was admitted to the Paediatric assessment unit on and later transferred to Ward M.
I'd initially took him to GP ..... Doctor saw us approximately one minute later, made a phone call which resulted in us being able to go straight to PAU. On arrival a lovely porter took pity on us and took us straight there where two doctors then saw him & agreed he needed to be seen by the surgeons for an appendectomy. This was at approximately 10am, we waited till 5pm where he was taken down for surgery. I later spoke to a fantastic nurse on night duty who gently helped me to recognise that going home to get some sleep was probably not the best idea (I think I must have been in denial!) and got a camp bed for me. Throughout our stay on ward M I can honestly say that the care & compassion my son received was outstanding. It's obvious to see how hard all members of staff work yet they remain kind and thoughtful throughout."

Princess of Wales Hospital:
My daughter was born in the Princess of Wales Hospital and the team that looked after me, my daughter and my husband were fantastic.
The midwife who delivered my daughter was amazing and I honestly don't think I could have done it without her. The registrar who stitched me afterwards was also fantastic. Not only did they deliver my baby, they looked after us afterwards as if we were family to them, made as laugh and smile when we needed it, made sure my husband was comfortable, helped us on that very 1st night when we didn't have a clue what we should be doing, gave encouragement and a cuddle when we needed it, made us countless cups of tea and toast and kept the overly keen visitors at bay!!

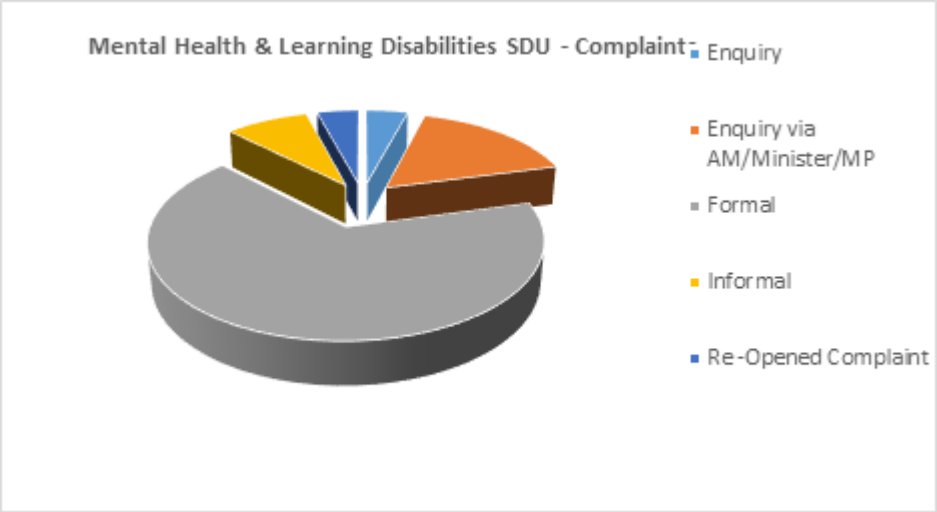
District Nursing Team, Clydach, Swansea:

"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".

Mental Health & Learning Disabilities SDU

1st November – 31st December 2017

Mental Health & Learning Disabilities SDU received 24 concerns.



Top 3 Complaint Trends

- Communication Issues (7)

There are no other trends for the above complaints

During November/December there were:

No never events
No redress
No personal injury claims
No clinical negligence claims

There was 1 re-opened complaint.

Compliment: *patient's wife found the support given by the team to her husband very helpful. She said that she has always felt quite negative about mental health services. However, being involved with Home Treatment Team due to her husband, she feels much more positive about mental health services and would like to pass on her thanks to the team.*

Incidents

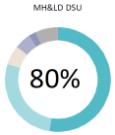
714 incidents were reported with the 3 top themes being:

- Inappropriate/Aggressive behaviour towards staff Psychiatric Intensive Care Unit (21), Llwynere (19) and Celyn Ward, Cefn Coed (9)
- Suspected slip/trip/fall –Ward G (NPTH (17), Ward 2, Angelton (15) and Derwyn Ward CCH (10)
- Inappropriate/Aggressive behaviour towards patient by a patient – Celyn Ward, CCH (15), Fendrod Ward, Cefn Coed (9) and Derwyn Ward CCH (9)

Serious Incidents (2) – unexpected death in the community (2)

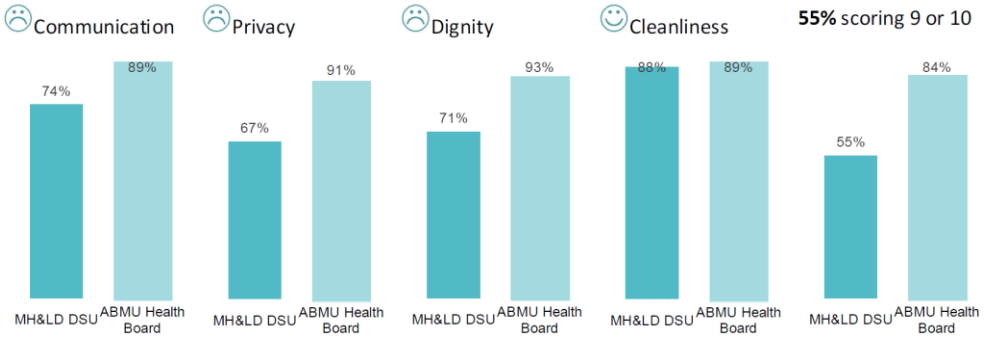
Claims & Redress

- 8 inquests – unexpected deaths in community (8)
- 2 Redress payments – Damages (1) and Legal Fees (1)



Friends & Family Results – November/December
of 84 respondents said they would be extremely likely or likely to recommend the clinical service.

All Wales Survey

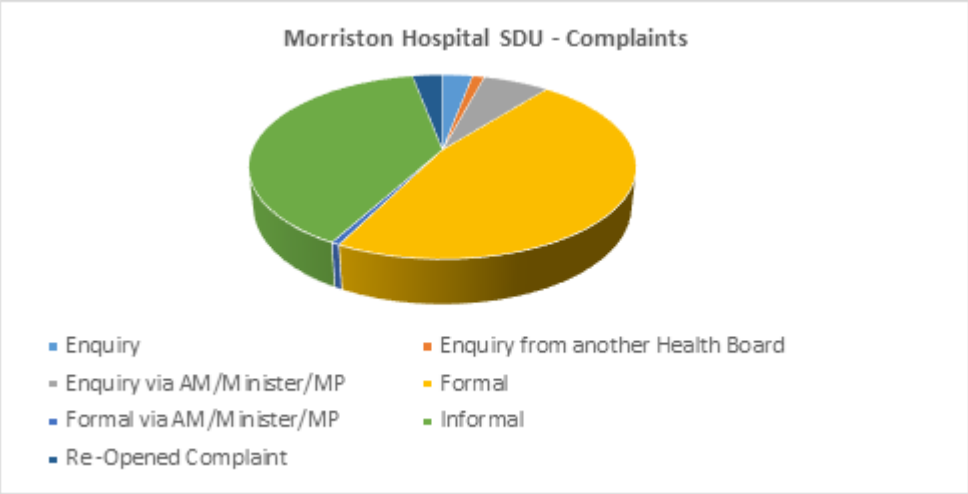


There were 24 All Wales Surveys completed for the Service Delivery Unit during November and December 2017

Morriston Hospital Service Delivery Unit

1st November – 31st December 2017

Morriston Hospital SDU received 167 concerns.



Top 3 Complaint Trends

- Admissions (37) – Cancelled admissions, delays and no date
- Communication issues (33) – Staff to patient verbal
- Appointments (33) – Delay in receiving and cancelled

Redress

- 5 redress cases
- 13 redress payments – Expert advice (6), Damages (5) and Legal fees (2)

There were a total of 7 reopened formal complaints for this period of time.

1 Never Event

Incidents

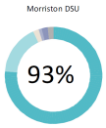
1,307 incidents were reported with the 3 top themes being:

- Suspected falls – Acute MAU West (18) Ward J (13) Ward F (12)
- Moisture Lesion - Acute MAU West (22), Ward J (13), Ward F and Acute MAU East (7 each)
- Access and Admission – Acute MAU West (30) Ward J (16), Ward F (9) and

Serious incidents (3) – Patient Falls (2) Therapeutic processes/procedures- NEVER EVENT (1)

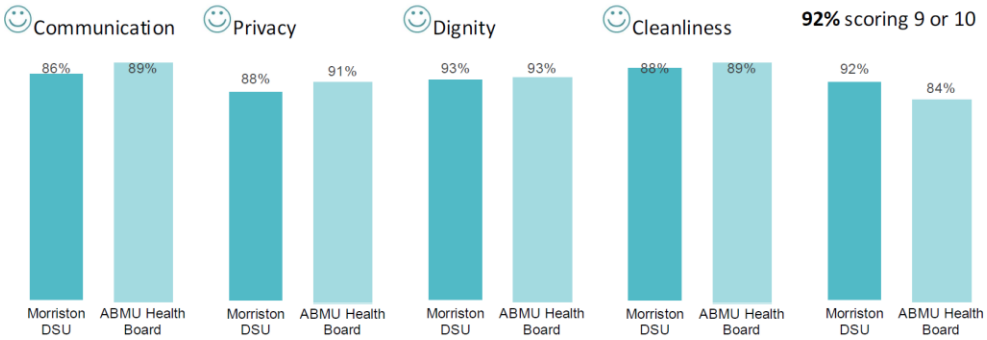
Claims

- 15 clinical negligence claims – Pressure Ulcer (1), Patient Fall (1), Therapeutic processes (6) and Diagnostic processes (7)
- 3 personal injury claims – Patient fall (1), Employee fall (1) and Violence and aggression to staff (1)
- 10 inquests opened – Unexpected deaths



- **Friends & Family Results – September/October**
- of 2,805 respondents said they would be extremely likely or likely to recommend the clinical service.

All Wales Survey



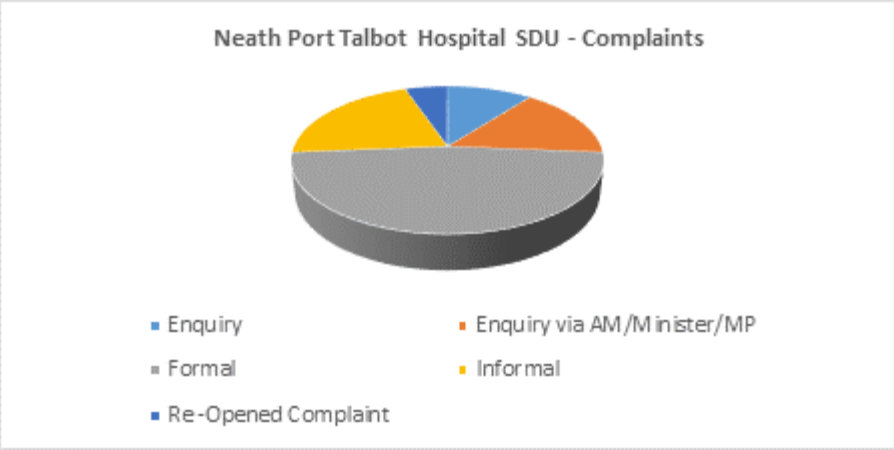
78 All Wales Surveys were received for the Service Delivery Unit during November and December 2017.

Compliment: *'You and the Board should be immensely proud as not only do you have exceptional nursing staff but Morriston Hospital itself was incredibly impressive. It was welcoming, well organised, spotlessly clean and staffed with some of the most kind and compassionate people on the planet.'* **A&E, Morriston Hospital**

Neath Port Talbot Hospital Service Delivery Unit

1st November – 31st December 2017

Neath Port Talbot SDU received 19 concerns.



Top Complaint Trend

- Communication issues (8)

There are no other themes for the above complaints.

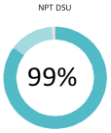
No never events
No personal injury cases
No inquests
No Serious Incidents

There was 1 re-opened complaint.

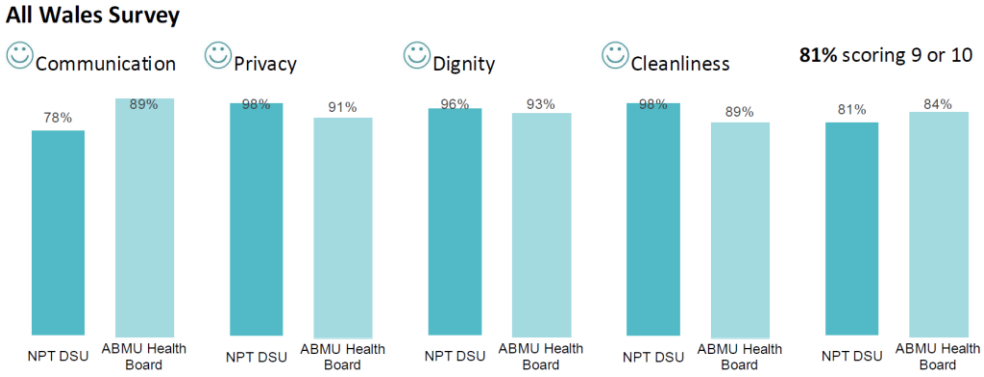
- **Incidents**
- **189** incidents were reported with the 3 top themes being:
- Suspected falls – Ward D (17), Ward B2 (13) Ward E (11)
- Witnessed falls – Ward B2 (8), Neuro Rehab and Ward D(2 Each)
- Inappropriate/Aggressive behaviour towards staff – Ward C (2) and five other areas (1 Each)

Claims & Redress

- 1 clinical negligence claim – Diagnostic processes
- 1 Redress Case
- 1 redress payment – Expert fees



Friends & Family Results – November/December
of 1,641 respondents said they would be extremely likely or likely to recommend the clinical service.



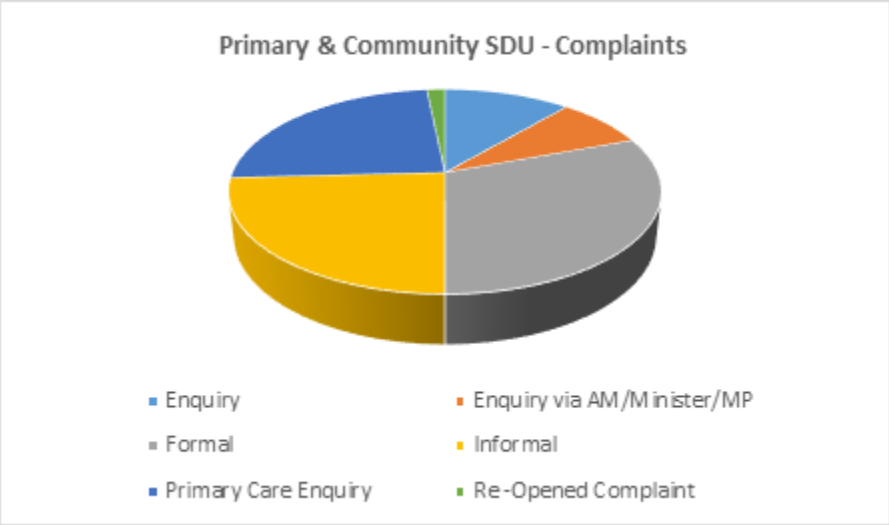
54 All Wales Surveys were received for the Service Delivery Unit during November/December 2017.

Compliment
"I can't thank you enough for all of your help. Went food shopping for the first time on my own last week! You made this happen."
Re-enablement Team, Community Physiotherapy

Primary & Community Service Delivery Unit

1st November – 31st December 2017

Primary & Community SDU received 62 concerns.



Top 3 Complaint Trends

- Communication issues (14)
- Appointments (7) – Delay in receiving appointment, and appointment cancelled

There are no other themes for this period.

There was 1 re-opened complaint for this period of time.

No personal injury
No clinical negligence
No inquests
No redress payments
No never events

Incidents

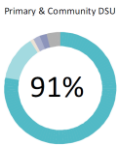
747 incidents were reported with the 3 top themes being:

- Pressure Ulcers – Patients home (64), Llwchwr North Hub, Bay Health Hub and City Health Hub (7 each)
- Moisture lesion – Patient's home (57), Llwchwr North Hub (9), City Health Central Hub (6)
- Injury of unknown origin – Patient's home (9), Llwchwr North Hub (6) Six others (1 each)

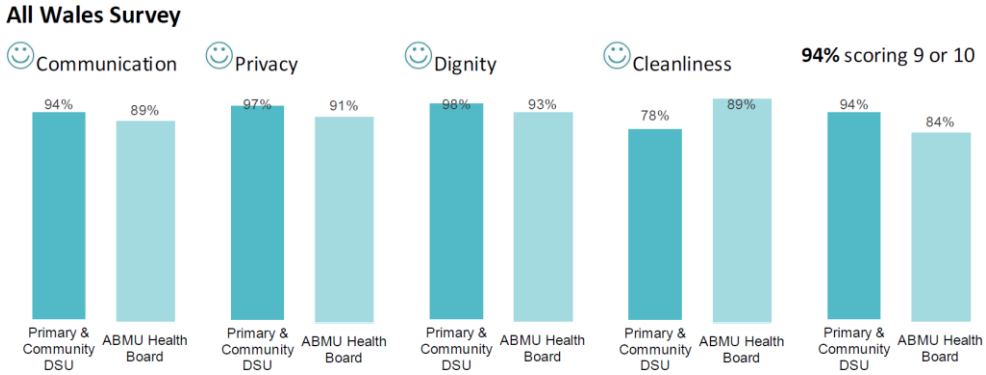
Serious Incidents (9) – Pressure ulcers (8) and Patient Fall (1)

Claims & Redress

- 1 Redress



Friends & Family Results – November/December
of 132 respondents said they would be extremely likely or likely to recommend the clinical service.



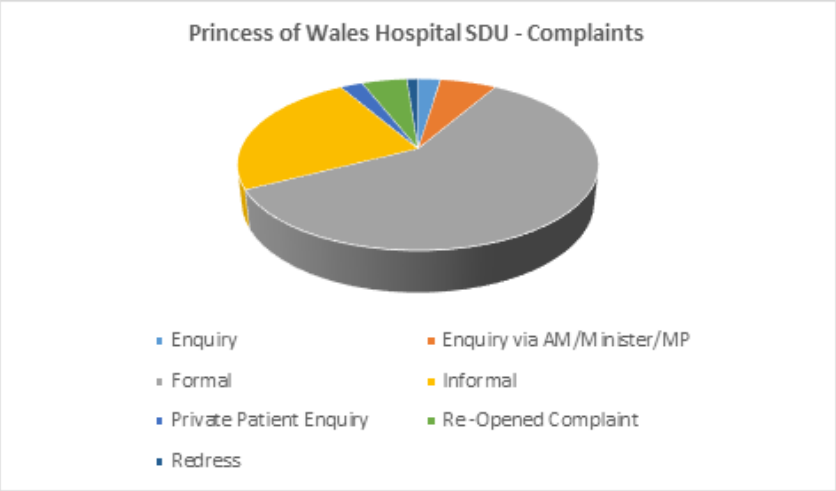
67 All Wales Surveys were received for the Service Delivery Unit during November and December 2017.

Compliment received:- *"I wish to commend you on the service you provide for stay at home patients. I receive excellent care from a dedicated professional team- who consider all aspects of my illness and give me medical treatment of 2 IV injections daily as well as weekly assessments"* ***Chronic Condition Management, Bonymaen Clinic***

Princess of Wales Hospital Service Delivery Unit

1st November – 31st December 2017

Princess of Wales Hospital SDU received 83 concerns.



Top 3 Complaint Trends

- Clinical treatment (19) – Incorrect diagnosis and lack of treatment
- Admission (10) – Cancelled or delay
- Appointments (8) – Delay in receiving or cancelled

Redress

- 8 redress payments made – Damages (3), Legal fees (3) and Expert advice (2)
- 8 redress cases
- 4 re-opened complaints
- 1 Never Event

Compliment *"I am writing as I feel compelled to express my sincere gratitude for the exemplary nursing care my late mother received on Ward 3, Coronary Care Unit. My mother was treated throughout with kindness and compassion. She was made comfortable, was treated with respect and allowed to die in peace".*

Incidents

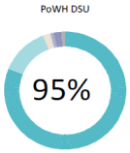
693 incidents were reported with the 3 top themes being:

- Insufficiencies/Failures/closures – A&E (20), Ward 6 (12), Wards 5 (7)
- Suspected falls – Ward 18 (12), Ward 5 and Ward 6 (9 each)
- Pressure Ulcers – Ward 8 (6), Ward 10, 7 and 4 (4 each)

Serious incidents (5) –Infection control (1), Therapeutic processes/procedures- NEVER EVENT (1), Pressure ulcer (1) and Service Disruption (2)

Claims

- 11 Clinical negligence (11) – Diagnostic processes (5) and therapeutic processes (6)
- Personal injury (1) - aggressive behaviour by patient towards a member of staff
- Inquests (3) – Unexpected deaths



Friends & Family Results – November/December
of 2,185 respondents said they would be extremely likely or likely to recommend the clinical service.
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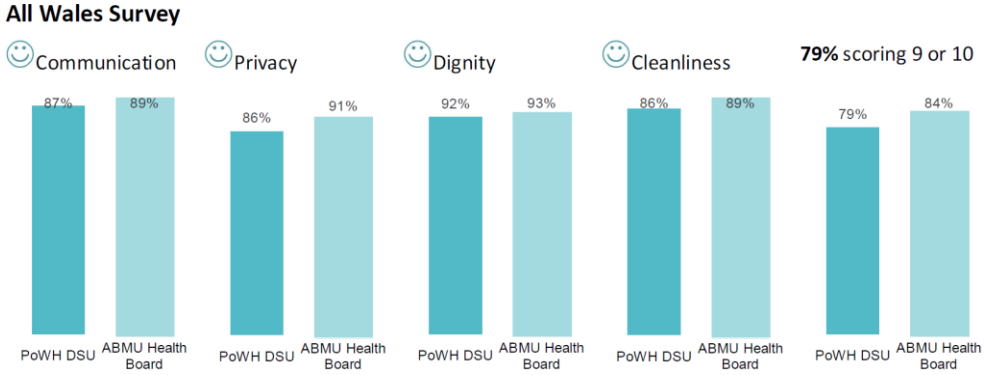
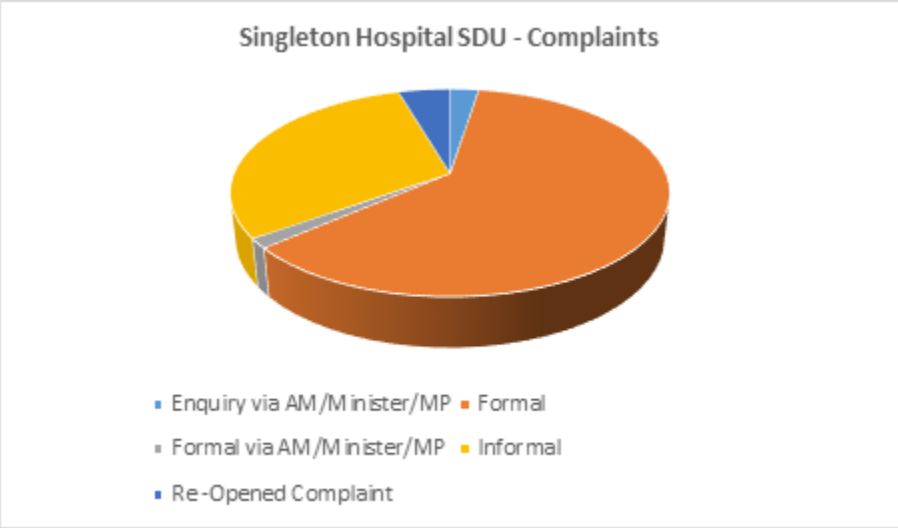


77 All Wales Surveys were received for the Service Delivery Unit during November and December 2017.

Singleton Hospital Service Delivery Unit

1st November – 31st December 2017

Singleton Hospital SDU received 74 concerns.



Top 3 Complaint Trends

Communication issues (14)

- Clinical treatment (9) – Delay in receiving, lack of treatment and delay in diagnosis
- Appointments (14) – Delay in receiving/Cancellations

There were 4 reopened complaints for this period of time.

No never events
No inquests

Redress

3 redress cases
3 Redress payments made – Damages (2) Legal Fees (1)

Incidents

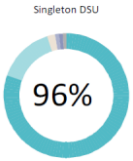
628 incidents were reported with the 3 top themes being:

- Suspected falls –Wards 4, 8 and 9 (11 each)
- Maternity Triggers – Labour Ward Central (23) Ward 18 (8) and Labour Ward Delivery Room (5)
- Administration to Patient – Ward 6 (5), Ward 18 Ward 3 and Neonatal Unit (3 Each)

Serious incidents (5) – Pressure Ulcers (2), Diagnostic processes/procedures (1) and patient falls (2)

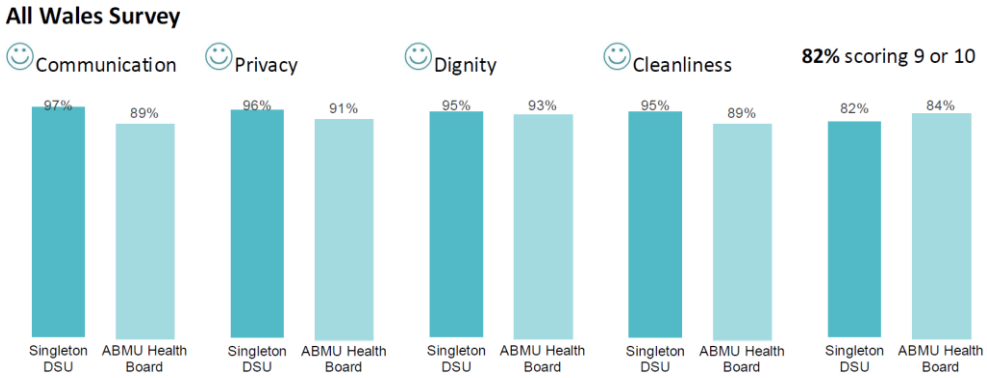
Claims

- Clinical negligence (8) – Diagnostic process (2), therapeutic processes (3) maternity care (2) neonatal/perinatal care (1)



Friends & Family Results – November/December

of 3,616 respondents said they would be extremely likely or likely to recommend the clinical service.



114 All Wales Surveys were received for the Service Delivery Unit during November and December 2017.

Compliment *"We just wanted to say a massive thank you for the wonderful care that you gave to our mother. Also thanks for all the support you gave to my father, brother and myself. You all do a fantastic job and are a credit to your profession"*

Ty Olwen

Learning Lessons from Units

As a result of the winter pressures the Assurance and Learning Group did not meet in January and the learning has been received for this report from the Units direct. The learning will be used in a Continuous Improvement Newsletter.

Mental Health & Learning Disabilities

Quality Improvement Programme

The Unit Nurse Director and Unit Medical Director are sponsoring a Quality Improvement programme that:

- Has a focus on 5 acute mental health wards and PICU
- Involves the whole MDT
- Includes the development of a ward based quality improvement plan which will be led by the Ward Medical Lead, AHP Lead and Ward Manger working as Quality Improvement Leads
- Include measurement and improvement teams will feedback progress to UMD and UND
- Involves external facilitators and Senior Clinical Nurses providing ongoing support to the Quality Improvement Leads to deliver on their quality improvement plans.

The programme as a whole will be evaluated

A series of Delivery Unit wide workshops will be set up to support the Implementation of the Improvement Plan. This will include workshops related to QI methodology and workshops identified as part of the individual improvement plans being developed by wards, for example; record keeping, concerns and redress, serious incident training, developing engagement with families and carers.

This approach will support wards to continuously approach, respond positively to the themes identified, develop staff skilled in improvement methodology and enable the Delivery Unit to evaluate a specific programme of improvement work to consider how further improvement work can be rolled out.

Patient experience – A task and finish group has been set up to implement the engagement strategy that has been developed by the Local Partnership Board. The implementation plan covers the four key areas laid out in the strategy:

- Information
- Involvement
- Recruitment and Training
- Deciding Together

Setting our commitments, actions and timeline for achievement.

In addition each Locality is setting up a local patient experience group that will support the implementation of the strategy and to ensure feedback on services including Patient and family experience including: Complaints and compliments, incidents, Claims, Safeguarding is analysed to support learning and improvement.

Morriston Hospital

INC69524 "Never Event" Wrong Site Surgery

A patient underwent planned Spinal Surgery with the intention of undertaking a procedure on L4/5 however the procedure was undertaken on L3/4. The patient has now undergone remedial surgery. A Health Board Strategy Meeting was held on the 13th December 2017 with NHS Wales Delivery Unit and an independent investigation is being led by the health Board's Serious Incident Team.

A reflective practice/learning event as part of the SI process has been held and the learning will be reported to the next meeting.

Neath Port Talbot Hospital

In December Neath Port Talbot Delivery Unit Quality, Safety and Improvement Group held a focussed session to reflect on lessons learnt and improvements made during 2017. Examples of this include:

- Learning from Pharmacy e.g. Face to face counselling, adjustments monitoring and supply delivered in a dedicated setting.
- Learning within Governance - Held a 'Values Based Concerns' workshop, encourage investigators to phone complainants, arranged meetings with investigators to review concern, final drafts of concerns are shared with staff for their comments before being sent, PEAS handle all informal concerns, included concerns on weekly performance reports and escalated those where we have not met internal deadlines.
- Learning from Physiotherapy e.g. A written 'physio plan' given to patients, early involvement of relatives and regular use of the friends and family test.
- Learning from Maternity e.g. On the 1st Tuesday of every month Maternity Services hold an OCRIM Meeting (Obstetric Clinical Review of Incident Meeting). Following these meetings a Communication Newsletter is cascaded to staff to ensure that themes/lessons learnt/actions from recent incidents are shared to minimise further incidents occurring.

Primary and Community Services

Long Term Care Team: Hospital Passport Scheme is currently being piloted in residential & nursing homes across all 3 Localities. This document is to improve communication between care home staff and hospital staff.

Bridgend East: Communication Improvement Pilot commenced in one network, following communication issues highlighted by the General practitioner and District nurses with the Residential homes MDTs now organised monthly at each residential home with District nurse, Social worker and General practitioner , to ensure a preventative and proactive approach to care needs of residents

Health Visiting:
Due to high no of Sudden Infant Deaths in 2016/17 – use of social media to reinforce safer sleep messages (40,000 views and 300 shares).

Princess of Wales Hospital

ID 1150 (Action Plan) – Reminder to staff to ensure that referrals on discharge to District Nursing Team are telephoned through to team to ensure continuity of care for patient. Contact numbers for the different networks flagged with all staff by Matrons/Ward Managers across POW. Cross reference of incidents in December 2017 highlighted that some issues were again being raised regarding contact not being received. Report flagged with Lead Matron & Matrons with contact list attached to reinforce details with staff again.

ID 307 (Action Plan) – Established no reasonable assessment of patients neurological and circulatory system resulting in a delayed referral to vascular team. New pathway in place and working well across site – this has been discussed and reinforced with staff. Monitoring process in place through incidents on Datix.

ID 94 RH (Action Plan) - Failure to abandon when complication during surgery occurred. Surgical department now have a protocol in place that two Consultants and adequate assistance is available in potentially complicated/high risk procedures.

INC 67461, 66602 & 65675. See attached SI Closure Forms which would have been taken to Assurance & Learning for discussion to ensure learning is shared and taken on board across the site.

INC 67461 As a result of an Infection Control investigation the following actions were taken:

- The Ward underwent complete refurbishment including full painting, renewal of ceiling tiles, replacement of bumper rails and damage walls repaired.

- All staff have received written guidance in relation to Infection Control including the collection of samples and isolation of patients.
- Ward Manager continues to deliver Clostridium Difficile training to nursing team. Infection Control Team have provided training to multi-disciplinary team. The presentation is available on ward computers for staff to view.

Singleton Hospital

- The increase in the number of Friends and Family feedback forms had been sustained and the Unit has continued to maintain a high level of satisfaction.
- The Unit had seen a reduction in falls and pressure ulcers as part of the Health Board wide improvement work.
- The Unit showed improving compliance against the 80% target of responding to complaints within 30 working days in June (81%) however this decreased in July (60%). The cause for this decrease was investigated and remedial processes were put in place. The processes were reviewed weekly and controls put in place to improve and sustain performance. The SSDU Quality & Safety team have managed the complaint responses and achieved the target of 80% and above in August, September and October.

Learning from Complaints and incidents:

- **ID-8795-** Patients to be offered the opportunity to review IPFR applications before they are submitted.
- **ID-9322-** referral process for Lymphoedema clinic re-enforced with staff to ensure that they are aware cancer patients can self-refer
- **ID-6418/ INC-36993-** Processes for reviewing outpatient monitoring scans for cancer patients reviewed to ensure new acute issues are promptly addressed.
- **ID-8975-** Limited capacity in specialist Optometrist clinics resulting cancellation of routine appointments to accommodate urgent referrals. Number of adult appointment slots under review.
- **ID-8953-** Teaching programme for Nurses and HCSWs caring for respiratory patients under development.
- **INC-57917-** report has been shared at unit Assurance and Learning meeting, Sisters meeting and Falls Action group.
- **INC-64204**- An IQC failure SOP is required to ensure a consistent approach is taken when an IQC failure occur. This should include communication of analytical failures to the reporting team. A SOP for the management of IQC was distributed 11/10/17. A specific SOP for actions to be taken on IQC failure is in progress. The SOP is in draft but requires completion to ensure a consistent approach to corrective action is taken when an IQC failure occurs
- **INC-64478**- Member of staff involved, allowed distractions to cause her to make an error. The family of the patient involved will distract staff while they are working and interrupt care. This was a factor in the staff member breaking safe working practice and signing before giving medication. Staff member involved has shared her experience with other staff on ward, and as a team we have be reminded that safe working practice has been put in place for our protection as well as the patients. Staff advised to ask family to leave room or to wait until a task finished before asking for any other care to be given. Staff not to allow pressure from patient or family to distract them while on drug round. Red apron to be worn to remind others that drug round in progress and not to disturb.

Patient Safety Notices and Alerts

Key Issues to note:

- Health Board is non-compliant with **two** Patient Safety Alerts which passed compliance date and **one** Patient Safety Notice, one passed its compliance date (it has been reopened following discussion with Patient Safety Solutions).
- The Health Board Risk Adviser is undertaking an exercise to review notices/alerts we have declared compliance with and check we remain compliant.

Non-compliant Patient Safety Alerts

- PSA 007 - Restricted use of open systems for injectable medication - The alert is being managed by Medicines Safety Group and has been escalated to the Director of Therapies and Health Sciences as Executive Lead. The alert consists of several components, all of which are compliant apart from the required audit. The Audit is underway and requires all Units to now provide assurance that all areas have been included. The Medicines Safety Group (MSG) will assess compliance with the alert at their next meeting on 19th January 2018.
- PSA 008 – Naso-gastric Tube misplacement: The Alert is managed by a Task and Finish Group. A major policy review and update is underway There are however, difficulties in compliance from a training perspective. An option paper is being presented to the Health Board Nursing and Midwifery Board in January 2018 which will outline the options for Health Board competency based training in Nasogastric Tubes and the decision reported back to the Task and Finish Group for consideration**.**
- PSN 030 - Construction of medicine cupboards - The safe storage of medicines: cupboards (originally Welsh Government advised that we could close it down if we had risk based action plans to complete the work. The Welsh Government Delivery Unit have advised that we must keep the alert open until all the actions are complete. The Risk Adviser has written to the Chairman of the Medicines Safety Group to inform him and to ask for a review of the action plan.
- A letter was received 24th November 2017 from Andrew Goodall Director General of Health and Social Services/Chief Executive NHS Wales and Andrew Evans, Chief Pharmaceutical Officer requesting Health Board self-assessment of Medicines Administration Recording Review and Storage (MARRS)-compliance with All-Wales Policy. The issue has been managed by the Medicines Safety Group and the Health Board is on target to return the information on time.
- PSN 039 Safe Transfusion Practice Use of a bedside Checklist. The Health Board are investigating whether we already comply with this alert. Deadline for declaring compliance is15 February 2018
- Each alert/notice lead has been requested to review their risk assessments in relation to non compliance with the alerts and to review their action plans and target date for compliance to reduce the risk of non-compliance with these alerts across the Health Board.

Each alert/notice lead has been requested to review their risk assessments in relation to noncompliance with the alerts and to review their action plans and target date for compliance to reduce the risk of non-compliance with these alerts across the Health Board.

Putting Things Right Policy

The Putting Things Right Policy has been reviewed through the Assurance and Learning Group and updated and is attached as **Appendix 2**. The Committee is asked to approve, subject to any final changes identified by the Committee Members.

Claims Policy and Procedure

The Claims Policy and Procedure has been updated and consulted on through the Assurance and Learning Group members and is attached as **Appendix 3 and 4.** The Committee is asked to approve, subject to final amendments identified by the Committee Members.

The Quality & Safety Committee is asked to

- Note the learning and improvement that is being implemented as a consequence of patient experience feedback;
- Consider the hotspot findings to inform the next 15 step challenge visit;
- Approve the Putting Things Right Policy;
- Approve the Claims Policy and Procedure;
- Support the ongoing development of this report and approach on patient experience by providing feedback from the Quality and Safety Committee.

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QUALITY ASSURANCE FRAMEWORK

IDEAL WARD TOOLKIT

Ward R – 15/12/2017

Unannounced Visit

Ward Information

Ward / Speciality	Ward R
Hospital	Morriston
Time of Day	11.30
Number of Staff on duty.	Registered Nurses (Established) – 4 + Ward sister supervising. Matron observed visiting ward numerous times Registered Nurses (Bank / Agency) – 0
	HCSW (Established) – 3 HCSW (Bank Agency) - 0
	Allied Health Professionals – Physio, CNS
	Medical Professionals – Many
	Students – 0
	Hotel Services Staff – Ward Host
Name and position of Reviewers	Rob Jones – Corporate Matron, Corporate Nursing Charlotte Higgins – Graduate Management Trainee, Corporate Nursing
Date of Review	15/12/2017
Date of last review	02/12/2017

Initial observations

29 beds

Funded establishment

Registered 20.06	Unregistered 9.56	Total 32.11

Vacancy -1.07 WTE Band 5

Target roster am6+3; pm5+4; night4+3

November's sickness 7.71%

Ward R is a busy 29 bedded surgical ward specialising in vascular surgery.

High acuity due to new amputees and patients comorbidities (eg diabetes/ischemic heart disease) resulting in vascular issues.

GOOD PRACTICE

Witnessed high standards of care/compassion:

- Conversations between staff and patients showed high levels of care, compassion, empathy and professionalism.
- Staff walking with patients, promoting independence whilst providing a reassuring support.

CONCERN

Medicines Management:

- Patient reported medication error – Given Warfrin prescribed for another patient. Patient on dialysis. – See Patient feedback section.
- Non- compliant member of staff with medicines administration policy (signing for medication before meds being taken)
- Drugs key found in cupboard of medication room (Main door to room locked).

Patient Experience

- **Pain management** – Patient report poor experience of pain

	management. Staff also highlight this as an issue. See Patient and staff feedback sections. • **Discharge Planning -** Poor documentation around discharge planning. This was also highlighted on the assurance visit last year. • **Communication –** Most of the negative feedback reported in the patient feedback section relates to poor communication between staff and patients. This issue was not just related ward nursing staff. For example, one patient had been on the ward for three weeks and had their operation cancelled ten times. Another patient reported receiving information from one Doctor which had not been handed over to staff. See patient feedback section. **Workforce** • Non-compliant staff with uniform policy. • Drs not compliant with bare below the elbow and dress code policy. **Infection Control** • Non-compliant member of staff with the correct procedure to dispose of PPE. • Ward is cluttered with cleaning trolleys, linen trolley and equipment in walkways. Due to limited storage and need to provide more equipment & mobility aids needed due to nature of patients, this is a daily risk for ward.

Feedback & Actions	Immediate feedback was provided to the Ward Manager on day of visit. The Unit Nurse Director was also given feedback on good practice observed and concerns. The full report will be presented to the Unit Nurse Director and Ward Manager.

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QUALITY ASSURANCE FRAMEWORK

IDEAL WARD TOOLKIT

SAFE CARE

CLINICAL OBSERVATIONS

POSITIVE	**Managing Risks:** 10/10 patients were observed to be wearing visible and clear armbands. **3 pieces of equipment were checked:** Dinamap, hoist and syringe driver pump all in good repair. Dinamap and hoist in date of checks, however pump had no visible date last checked or service. **Infection Prevention Control:** • There was no rubbish or dirty linen on display or stored inappropriately in ward area. • Floors, ceilings etc were generally in good repair. The ward sister commented that the flooring had been repaired within the last year. • IPC information clearly displayed at ward entrance, 5 steps to hand hygiene displayed in ward area, 2 visible hand sanitisers on ward, 1 outside. • Good observation of hand hygiene technique by staff after patient contact and other tasks. **Medicines Management:** • Staff were observed to check patient details prior to giving medication • Medication was stored securely in patient lockers. • A staff member was observed providing an explanation of paracetamol to a patient whilst administering. **Nutrition and hydration:** • Were appropriate, patients were encouraged to sit out for lunch and prepared for their meal by the physio. However, no patients given the opportunity to wash their hands before eating.

REQUIRES IMPROVEMENT	**Managing Risks:** • Lighting on ward is not adequate for inspecting wounds. This has been brought up numerous times, and was also noted in last year's quality assurance visit. Doctors are using torches for improved visibility which is not appropriate. • Equipment blocking 3 fire exists - hoist, Zimmer frame, blood pressure machine and wheelchairs. • Cleaning tablets not locked in sluice cupboard. **Resuscitation Trolley:** 2 months were reviewed for resuscitation trolley checks. A number of dates were missing from resuscitation trolley check list – 11/12/17, 7/12/17, 6/12/17, plus five days in a row at the end of November. The resuscitation Trolley was not plugged in when checked during the visit. **IPC:** Staff observed on numerous occasions not disposing of PPE equipment in isolation room. Observed to dispose in bins outside of the room. Doctors visiting ward observed not following bare below the elbows policy. One Doctor observed wearing a scarf, another observed with long hair not tied back. Patient tables in poor repair. Ward Sister requested new tables after last IPC audit. **Medicines management:** The medication room door was locked, however a key was found in the door to one cupboard. A member of staff was observed signing for medication while dispensing into pot.

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QUALITY ASSURANCE FRAMEWORK

IDEAL WARD TOOLKIT

EFFECTIVE CARE

CLINICAL OBSERVATIONS

POSITIVE	**Signage:** All signs on the ward displayed clearly on toilets, shower room etc. Dementia friendly symbols used throughout ward. **Communication:** Doctor on ward confirmed that a Nurse is present to support patients during contact with Doctors when appropriate. A Board Round was observed. MDT approach including ward receptionist, physio and CNS present.

REQUIRES IMPROVEMENT	No Doctor present during Board Round. When review team asked Doctor on ward if they usually took part, the Dr was not aware that board rounds took place on the ward.

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IDEAL WARD TOOLKIT

DIGNIFIED CARE

CLINICAL OBSERVATIONS

POSITIVE	Staff members were observed to communicate with patients in a caring and dignified manner. One HCSW impressed the reviewers with how she addressed a patient with dementia, which was fed back to the ward Sister. Patients looked comfortable and well cared for.

REQUIRES IMPROVEMENT	Most patients were observed to be wearing nightwear instead of day clothes. The reviewers asked one patient, who was wearing day clothes if staff had encouraged her to do so. The patient fed back that it was her decision to wear day clothes, and she had not been prompted by staff. **Pain - Two NEWS charts were checked:** • Missing information on one NEWS chart. • Pain documented as 0 on NEWS chart, however evidence in drug chart showed that PRN paracetamol with the indication written as pain was given at this time.

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QUALITY ASSURANCE FRAMEWORK

IDEAL WARD TOOLKIT

INDIVIDUAL CARE

CLINICAL OBSERVATIONS

POSITIVE	**Patient Information:** Good range of clinical information displayed for patient information. All in appropriate font, display colours, clearly displayed. Accessible information regarding how to raise a complaint – Lets talk, friends and family, PALS. **Patient experience:** The review team asked the ward manager about the escorting policy following the issues raised in a recent complaint. The ward Sister said that staff may not be aware of escorting policy. She does feel that practice has improved since incident through reflection and learning - Receptionist takes call, relays information to Nurse in charge to clarify where patients are going. The receptionist is also now involved in board round also.

REQUIRES IMPROVEMENT	**<u>Patient experience:</u>** Access ok, but difficult for wheelchair users. Due to the nature of the ward, patients require assistance with mobilising and extra equipment on ward. The number of aids required exceeds the storage available. Discharge planning: 3 sets of notes were reviewed for discharge planning. This area was found to be poorly documented during the assurance visit last year. Missing information around many aspects of the discharge planning documentation. This was also picked up at last year's quality assurance visit.

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QUALITY ASSURANCE FRAMEWORK

IDEAL WARD TOOLKIT

WORKFORCE

CLINICAL OBSERVATIONS

POSITIVE	Clinical staff wearing identification badges and most complying with All Wales dress code – One staff members with ring in nose.

TRAINING COMPLIANCE	<u>November's data</u> Compliance with hand hygiene training = 83% Compliance with hand hygiene (WHO 5 moments) (monthly) = 100% Staff compliant with standardised infection precaution training = 80% Staff up to date with level 2 child protection training = 31% Staff who are up to date with POVA Training = 54% Staff who are up to date with MCA / DoLs Training = 56% (Staff booking on dates in new year) Staff who are up to date with V&A Training (in accordance with local risk assessed frequency) = 59% Staff who are up to date with Fire Training = 71% Staff who have had a manual handling competency signed off / or received update training in the last 12 months = 92.5% Staff who are up to date with Life Support Training = 72% Staff involved in blood transfusion who have had blood transfusion training in the last 24 months = 50% HCSWs who have fully completed the band 2 competency booklet = 90% Staff who have fully completed the All Wales Food Chart e-learning tool = 59% Designated registered nurse mentors up to date with annual

	mentorship training = 50% Designated registered nurse mentors who have mentored at least 2 students in the last rolling three year period (NMC triennial review criteria) = 100%

PATIENT FEEDBACK

Three patients were spoken to during the visit.

Patient 1 – Has been on ward for 3 weeks. His operation has been cancelled 10 times due to no ITU bed.

Patient 2 – Has been on ward for 2 weeks. Is from Bridgend and was originally in POW Hospital.

Patient 3 – Due to be discharged on day of visit. At 2pm still no decision made and had not been informed what he was waiting for.

POSITIVE	**Pt. 1** – '*Staff treat me well*' **Pt. 2** - '*Nothing to mention'* **Pt. 3** – '*Call bell answered promptly at night. The nurses are dedicated, they try their best*'
CONCERNS	**Pt. 1 –** Patient reported that he was given Warfrin when he shouldn't of had it as he is on dialysis. He reported that the medication was prescribed for the patient opposite him and given to him in error. Patient is frustrated that he was called in urgently for operation 3 weeks ago. Apart from a few scans he has had no treatment so far. His operation has been cancelled 10 times. **Pt. 2** – *'Staff are rushed off their feet. I Have not been put on my infusion yet (2pm), it was due at 10am'.* Patient reported of late administration on other days. Patient reported that on previous day she was on infusion till late at night when visitors are with her. The patient lives in Bridgend and was originally receiving treatment in POW Hospital. The patient reported that she was told by a Doctor days ago that she could be transferred back to POW which she was happy about as she feels isolated from family and friends in Morriston. The patient said that when she asks staff what's going on they reply with 'I'll find out what's happening' but so far have not

	given her a straight answer. The patient has reported that the situation has given her anxiety. **Pt. 3** – Patient reported that Doctors come around each morning to inspect his wounds, but then they are left undressed for some time (up to 2 hours) before Nurses are able to redress. Patient is aware that this is an infection risk. As the problem is a podiatry problem the patient reported that often the dressing he requires are not in stock. Patient is aware that he is in a different specialist area but feels that this is poor management and wastes time having to go and find stock each day. When the patient goes down to podiatry outpatients each day his wife attends with him. Patient feels that staff should attend on one occasion to observe how his wounds can be dressed - Wife has more knowledge of redressing wound but the staff don't as they don't see how it is done and this results in poor attention to detail when redressing. However, he understands staff shortages. The patient reported that during the day his call bell isn't answered promptly and he is waiting long lengths of time. He mentioned that when he is given pain relief he is not asked a while after if pain has gone. Patient reports that when he asks staff for something they often get distracted and he can be waiting a while for response. The patient mentioned that the TV remote has been missing from his room throughout his stay. He said that the TV is put on every day but he is unable to change the channel.

WHAT COULD IMPROVE PATIENT EXPERIENCE	**Pt. 1** – The patient felt that improved organisation is needed on the ward. **Pt. 2 –** The patient commented that improved Communication is required. **Pt. 3** – Improved Commutation to inform patients what is happening with their treatment.

STAFF FEEDBACK

POSITIVE	Staff felt that they were treated with dignity and respect in work. All felt that they were supported by Senior members of staff. All staff felt that they were provided with feedback of outcomes from incidents. It was reported that feedback was received through team meetings and 1-2-1 feedback. One member of staff did report that team meeting do not take place as often as they have previously. Most staff felt that they were given opportunities to enhance their skills and professional development. The staff member who was observed communicating well with a patient with dementia reported that she had attended dementia training. Staff reported they enjoy working on the ward due to the challenges and learning opportunities.
CONCERNS	**Staff felt that they don't work in a safe environment at times:** • *'Staffing is not adequate for ensuring standards for practice. Pressure on staff has been high'* • *'At times when understaffed, there are not enough staff for patients. Patients get level of care, but staff are running round and tasks are not done quickly'* • *'When we are short staffed I feel rushed and could do with another HCSW'*
IMPROVE STAFF EXPERIENCE	All staff felt that extra staff would improve their experience.

IMPROVE PATIENT EXPERIENCE	One member of staff felt that patients pain is not well managed. They felt that this is due to the large amounts of patients who receive controlled drugs and therefore they can spend up to 1.5 hours administering them. This staff member also reported high use of I.Vs which contributes to this issue. One member of staff thought that more time dedicated to patients such as time to talk to them about concerns etc.

PUTTING THINGS RIGHT POLICY

Policy Owner:	***Assurance & Learning Group***
Policy Approved By:	***Quality & Safety Committee***
Issue Date:	***April 2015***
Review Date:	***April 2018 (Policy has been reviewed and updated)***
Re issued:	

1. PURPOSE

1.1 This is a high level Policy supported by a number of standard operating procedures and should be read in conjunction with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and Putting Things Right Guidance on dealing with concerns about the NHS from 1st April 2011. Please note that section 18-21 of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 deals with the management of concerns relating to Primary Care Providers, who are not part of the Redress arrangements, and is important to note when considering the management of a joint concern between primary and secondary care

1.2 The Policy and its accompanying standard operating procedures detail the Health Board's arrangements for handling concerns and redress notified by persons in respect of services provided by or under arrangements with the Health Board and covers concerns which are made up of:

- Complaints;
- Patient Safety Incidents;
- Redress cases made by patients up to the value of £25,000

1.3 The purpose of the 'Putting Things Right' legislation is to:

- allow for redress to be provided in circumstances where there is a qualifying liability in tort in relation to the provisions of qualifying services. Redress may encompass apologies, explanations, action plans, remedial treatment and, if appropriate financial compensation.

- develop a culture of accepting and supporting when dealing with concerns about treatment and care, with staff at all levels being encouraged to apologise for adverse outcomes and to offer explanations why they may have arisen.

- ensure a patient/user focus rather than process-driven, approach is evident throughout the organisation, which also empowers people to raise concerns and have them dealt with as soon as they arise.

- emphasise the importance of resolving concerns in a timely fashion, openly and honestly – a philosophy of "investigate once, investigate well".

- Ensure staff can be confident that investigations will be fair and impartial and that they will be supported throughout the process.

- Ensure learning from concerns and errors drives quality improvement and reduces adverse events, and avoidable harm to patients/users.

2. POLICY AIM

2.1 The aim of this Policy is to outline how the Health Board will comply with the Putting Things Right legislation.

2.2 In support of this the Health Board will publish arrangements for dealing with concerns in a variety of media, formats and languages and will include the internet and via posters and leaflets in public areas.

3. POLICY SCOPE

3.1 This policy applies to all staff, permanent and temporary, employed by or working within the Health Board, including independent providers who have responsibility to report, manage and or be involved in concerns raised.

The Policy covers concerns about:

- Services, care & treatment provided by the Health Board;
- Services, care & treatment provided by Health Board employed staff;
- Services, care & treatment provided by independent contractors;
- Services, care & treatment provided by the independent or voluntary sector which are funded by the Health Board.

Independent contractors are required to have a concerns procedure in place for their NHS patients that is in line with the regulations.

3.2 This policy does not apply to clinical services provided privately, even when provided within Health Board premises, but it will apply to concerns about Health Board services or facilities used as part of that private service.

4. POLICY FRAMEWORK AND DEFINITIONS

4.1 This Policy will be the overarching Policy for the Putting Things Right management of concerns and redress and sets out the principles for the handling of the investigations. The Policy is supported by a number of standard operating procedures, provided as appendices, and also should be read in conjunction with the following documents:

- National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011;
- Putting Things Right Guidance on Dealing with Concerns about the NHS From 1st April 2011;
- Patient Safety Incident Procedure;
- Serious Incident Procedure;
- Complaints Procedure;
- Claims Management Policy;
- Inquest Policy;
- Being Open Policy;
- Welsh Risk Pool Standard 5 Concerns and Compensation Claims Management Standard.

4.2 Definitions

CONCERN	Means any complaint, claim or reported patient safety incident to be handled under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.
COMPLAINT	Any expression of dissatisfaction made by a patient, carer, relative. A formal concern is an expression of dissatisfaction either verbally or in writing that is graded as a 3, 4 or 5 and a relevant and proportionate investigation must be undertaken. An informal concern is a verbal or written concern raised by a member of the public, that could potententially be resolved immediately or within 2 working days through discussion explanation or the provision of information to the satisfaction of the person raising the concern. The informal process would usually be applied to concerns graded 1or 2. However there may be exceptions where a grade 3 will be managed informally if that is the request of the complainant.
PATIENT SAFETY INCIDENT	Any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS funded healthcare.
RESPONSIBLE BODY	(a) a Welsh NHS body; (b) a primary care provider; or (c) an independent provider.
PATIENT	A person who has received or will receive clinical services from the Health Board.
CHILD	A person who has not attained the age of 18 years
OFFICER MEMBER	A member of the Board who is an employee of the Health Board
NON-OFFICER MEMBER	A member of the Board who is not an employee of the Health Board
QUALIFYING LIABILITY	As a result of a breach of duty of care, harm has been caused to the patient relating to the care/treatment provided by the Health Board.
INDIVIDUAL PATIENT TREATMENT REQUESTS	A request to the Health Board to fund healthcare for an individual patient that falls outside the range of services and treatments that the health board provides, including those specialist services secured through WHSSC

5. GENERAL PRINCIPLES FOR THE HANDLING AND INVESTIGATION OF CONCERNS

5.1 In accordance with the requirements of the Regulations, the Health Board's arrangements for the handling and investigation of concerns are intended to ensure:

- a single point of logging formal concerns for the submission of concerns;
- concerns are dealt with efficiently and openly; demonstrating the Health Board values;
- concerns are properly investigated and responded to in a values based manner;
- action is taken to establish the expectation of the person notifying the concern and to seek to secure their involvement in the process;
- persons raising concerns are treated with respect and courtesy;
- persons who notify concerns are advised of:
    - the availability of assistance to enable them to pursue their concern;
    - where they may obtain such assistance, if it is required;
    - the name of the person who will act as the Health Board contact throughout the handling of the concern;
- consideration is given to the making of an offer of redress where the Health Board's investigation into the matters raised in the concern reveals that there is a qualifying liability in to whilst noting that Redress is not applicable to primary care providers;
- persons notifying concerns receive a timely and appropriate response within the bounds of receiving the appropriate consent;
- persons who notify the Health Board of concerns are advised of the outcome of the Health Board's investigation providing the appropriate consent has been received by the Health Board;
- appropriate action is taken in the light of the outcome of the investigation;
- the Health Board's arrangements take account of any guidance issued by Welsh Ministers.

6. ROLES and RESPONSIBILITIES

6.1 The Regulations specifically require every NHS organisation to make it clear who is responsible, in their organisation, for the undertaking of three distinct roles each of which has clear and distinct regulatory responsibilities as set out below:

Strategic oversight of the arrangements

A nominated Non-Officer Member must assume responsibility for maintaining a strategic overview of the operation of the Health Board's arrangements (under the Regulations), particularly as regards ensuring that:

- the Health Board complies with these arrangements;
- the Health Board has arrangements in place to review the outcome of the investigation of any concern, in order to ensure that any deficiencies in actions or service provision that have been identified by the investigation, are acted upon and monitored;
- lessons learned are identified and promulgated throughout the Health Board in order to improve the services that it provides and to seek to reduce future risk.

In the case of ABMU Health Board this role has been designated to the Chairman of the Quality and Safety Committee.

Responsible Officer

The Regulations specify that the Responsible Officer is responsible for the effective day to day operation of the Health Board's arrangements for dealing with concerns in an integrated manner. The Director of Nursing and Patient Experience is the Responsible Officer for ABMU Health Board. [In relation to these regulations 'integrated manner' means that the process for dealing with concerns and claims management (where there is a duty under the Regulations to consider qualifying liabilities) are dealt with under a single governance arrangement.]

The regulations allow for the functions of the Responsible Officer to be performed by the Director of Nursing and Patient Experience or any person authorised by the Health Board to act on behalf of the Executive Director of Nursing and Patient Experience.

Senior Investigations Manager

Under the Regulations, the Senior Investigations Manager is responsible for:

(a) the handling and consideration of concerns in accordance with this Policy;
(b) performing such other functions relating to the handling and consideration of concerns as the Health Board may specify;
(c) ensuring co-operation with such other persons or bodies as may be necessary to facilitate the handling and consideration of concerns.

The Assistant Director of Nursing & Patient Experience is the Senior Investigations Manager for ABMU Health Board.

In relation to 'performing such other functions relating to the handling and consideration of concerns as the Health Board may specify', the Assistant Director of Nursing & Patient Experience is responsible for:

- The operation of the Ombudsman and Complaints Team, Legal Services Department, Datix Team ,Risk Management Team , Serious Incident Team, Patient Experience Team and its resources;
- the development, integration and embedding of a comprehensive investigation and redress system for concerns,

- acting as the Health Board's Lead Investigation Officer; to lead, facilitate and provide advice on the investigation and analysis of concerns;
- overseeing the investigation of all serious concerns;
- personally investigating and analysing any individual concern when requested to do by the Executive Team;
- Overseeing the effective management and administration of the Datix system;
- Provide assurance to the Board on the Service Delivery Units performance;
- Ensure lessons learned are shared across Units.

6.2 Health Board - General

The Health Board is required by the Regulations to ensure that, at all times, the Senior Investigations Manager has a sufficient number of staff, of the required level of seniority and skills, to assist them in the carrying out of the functions that fall to the Senior Investigations Manager. Further, members of staff must receive adequate training to enable them to fulfill their responsibilities as specified.

The Regulations allow for the functions of the Senior Investigations Manager to be performed personally by them or by a person or persons authorised by the Health Board to act on behalf of the Senior Investigations Manager. If the Health Board should authorise any person to perform the required functions on behalf of the Senior Investigations Manager, the relevant details must be publicised.

The Health Board will ensure that all staff are informed about and receive appropriate training in respect of the operation of this Policy.

6.3 Non-Regulatory Responsibilities

6.3.1 Executive Team

The Medical Director and Director of Nursing and Patient Experience have joint responsibility for quality and safety and will provide leadership and support to ensure that the aims of this policy are achieved. They are both responsible for providing authority to admit a breach of duty in respect of their professional accountabilities and consider the Unit Directors views on admissions.

6.3.2 Unit Medical Directors, Unit Nurse Directors, Unit Service Directors , are responsible for ensuring:

- that a culture of openness is promoted and encouraged to ensure that staff report all concerns that are patient safety incidents and that concerns are robustly investigated in line with the Regulations and acted upon;
- effective and practical local arrangements are in place across all provided and commissioned services to ensure full implementation of and compliance with this policy and that these are communicated to staff;
- that all staff receive concerns handling, redress, customer care & nipping issues in the bud, and Datix training pertinent to their roles and responsibilities;
- that there is appropriate cross Service Delivery Unit co-ordination and liaison to achieve compliance with this policy;

- that adequate and appropriate support is made available to staff who are involved in/are the subject of a concern;
- that staff trained in investigations analysis within the Managed Service Delivery Units and are released or have their duties appropriately adjusted to enable them to undertake or support investigations when required;
- that all information pertaining to individual concerns including the outcomes of all investigations are fully and accurately recorded in Datix, that all documents are saved against the Datix record, and all action plans are completed through the Datix system so that compliance can be easily monitored and reviewed;
- that all necessary actions are taken to prevent re-occurrence of issues arising from both individual and aggregated concerns;
- appropriate communication and reporting of relevant information to all appropriate Groups/Committees;
- that lessons are shared across services and the Health Board as relevant;
- create a culture across services where issues are resolved as they arise and informally as far as possible – not allowing unnecessary escalation or protraction of concerns;
- ensure that 80% of concerns are responded to within 30 working days and no concerns receive a response later than 60 workings days (Regulatory maximum time period);
- Unit Datix (patient safety) dashboard is reviewed regularly and core outcomes reported to Groups/Committees/Unit meetings to assist decision making.

6.3.3 Every manager in the Health Board should:

- ensure all staff, volunteers and contractors are made aware of this policy and the requirements within it;
- create a culture where patient feedback is encouraged and timely action is taken to make any changes required;
- create a culture where all staff are supported and trained to address issues and concerns as they arise as to nip issues in the bud and to ask for help and assistance when required and not allow issues to fester and escalate;
- create and sustain an environment whereby staff feel supported to report concerns that are patient safety incidents and feel that these will be taken seriously and dealt with appropriately;
- ensure appropriate feedback is given to the reporters of patient safety incidents and all staff involved with or the subject of any concern, including any investigation outcomes and actions taken and to ensure that this feedback is clearly documented;
- ensure appropriate feedback is given to any reporter of a matter that is not considered to be a patient safety incident and information provided on what alternative action(s) will be taken;
- identify the training needs of individual members of staff, in relation to use of Datix and the handling of concerns, through performance review and PADR and determine a plan to ensure those needs will be met
- ensure their staff are made aware of how to access copies of the Health Board's arrangements for handling concerns, in all the formats, so that they may satisfy any reasonable request made of them for this information.

6.3.4 All Staff employed by the Health Board

All staff must:

- treat persons notifying concerns with respect and courtesy;
- address issues and concerns as they arise and escalate for assistance if unable to manage the matter;
- ensure that patient safety incidents that they are aware of are reported, no matter how minor they might appear. This ensures that the Health Board has the opportunity to take all appropriate actions under this policy including learning from such events and improving matters for the future;
- ensure they report patient safety incidents brought to their attention by patients and other persons. However, patients and other persons are equally entitled to complete and submit an incident report to the Health Board if they wish to do so. Staff should ensure assistance is given in such instances;
- all staff should ensure they are aware of how to access copies of the Health Board's arrangements for handling Concerns, in all the formats, to enable them to satisfy any reasonable request made of them for this information;
- be open, honest and transparent at all times; and
- adhere to this Policy and supporting procedures.

6.4 Supporting Groups/Committees

All staff supporting Groups/Committees will need to interrogate relevant patient safety data within the Datix System to produce any information on concerns that may be required by those Groups/Committees.

6.4.1 Assurance and Learning Group

This Group focuses on learning from themes/trends and high risk concerns. The Assurance and Learning Group reports to the Quality and Safety Forum.

6.4.2 Quality and Safety Forum

The Quality and Safety:

- considers Putting Things Right Policies to endorse approval by the Quality and Safety Committee and approves all relevant Standing Operating Procedures;
- oversee compliance with the Health Boards Risk Management Strategy and Putting Things Right Policy and affiliated policies, as necessary to ensure compliance with the Strategy and Regulations;
- receive reports at Corporate Directorate Level and Unit Level in order that key issues can be identified and learning can be shared;
- scrutinise themes and trends for escalation to the Quality & Safety Committee;
- receive exception reports on patient safety alerts and notices and agree actions required for action and monitoring;
- highlight risk issues that require consideration at a Health Board wide level; and
- highlight risks which require specialist review to the appropriate Corporate Group/Committee for consideration and the Executive Lead.

6.4.2 Quality and Safety Committee

The purpose of the Quality & Safety Committee is to provide:

- evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and

- assurance to the Board in relation to the Health Board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.

The Quality & Safety Committee will receive and commission reports from the Quality and Safety Forum to support achievement of these objectives. A Patient Experience report will be provided at each meeting.

7. WHO MAY RAISE A CONCERN / COMPLAINT

7.1 Persons Who May Notify Concerns / Complaints

Almost anyone can raise a concern and the Health Board will be under a duty to consider whether it can be investigated. However, it may not always be possible to share the full details of the investigation with the person raising the concern, for instance if they are not the patient or a person recognised as having authority to access the information.

As set out in Regulation 12 a concern may be notified by:

(a) people who are receiving or has received services from the Health Board,

(b) any person who is affected, or likely to be affected by the action, omission or decision of the Health Board, in relation to the functions of the Health Board;

(c) any non-officer member of the Health Board;

(d) any member of staff of the Health Board;

(d) any person acting on behalf of any person from the above categories (a to d) who has died, is a child, lacks the capacity under the Mental Capacity Act (2005) to notify the concern themselves or has requested the person to act as their representative.

(e) Assembly Members and Members of Parliament

7.2 Concerns Notified by a third party

When a third party acts as a representative on behalf of another e.g. a child or someone who lacks mental capacity if there are reasonable grounds to conclude that they are not suitable to act on their behalf, for example because it does not appear to be in the patients best interests, then they must be advised in writing. However, an investigation into the issues raised may still need to be undertaken. In this instance the Health Board is under no obligation to provide a detailed response to the person who raised the concern, unless it is reasonable to do so.

Concerns raised on behalf of a child / young person

Where a concern is notified by a child, the Health Board must provide the child with any reasonable assistance that the child requires in order to pursue the concern. Specialist advocacy may be required.

In many instances, someone else (parent/ carer/guardian) will raise a concern on behalf of a child / young person. This does not remove the right of the child / young person to take the concern forward themselves with support. The Health Board must satisfy itself whether the child / young person wishes to raise the concern themselves, with support, or if they are happy for the person who raised the concern to represent them. If the child / young person is not willing to proceed with an investigation then a decision will need to be taken about proceeding and specialist advice sought if appropriate. Particular regard needs to be given to safeguarding issues, and it may be necessary to proceed with an investigation, even if a child appears unhappy to do so. The Health Board is under no obligation to provide a response to the person who raised the concern in the first instance.

7.3 Concerns Notified by Staff

Staff wishing to report that something has gone wrong with the care or treatment provided to patients should do so via Datix Web (the Health Board's on-line Incident Reporting mechanism). Where a concern is notified by a member of staff and the initial investigation determines there has been harm, the Health Board is required to:

(a) notify the patient or his/her representative of the notified concern, and
(b) involve the patient, or his/her representative in the investigation of the concern

This notification and involvement will be undertaken in accordance with the Being Open Policy.

Where it is considered that it would not be in the interests of the patient to be informed of the concern or involved in the investigation, the Health Board is required to:

- make a written record of this decision and the reasons for it, and
- keep the decision under review during the investigation of the concern.

8. MATTERS & CONCERNS EXCLUDED FROM CONSIDERATION UNDER THIS POLICY

Not all concerns can be dealt with under the regulations. Matters excluded are set out in regulation 14 and include:

(a) A concern notified by a Primary Care Provider relating to the contract under which it provides Primary Care services - these are to be managed through the contractual arrangements;

(b) A concern notified by any member of staff relating to that person's contract of employment - these are to be managed through the Health Boards HR procedures;

(c) A concern that is being or has been investigated by the Public Services Ombudsman for Wales;

(d) A concern arising out of an alleged failure of the Health Board to comply with a request for information under the Freedom of Information Act 2000 – these would be dealt with by the Information Commissioners Office;

(e) Disciplinary proceedings that the Health Board is taking or proposing to take, arising from the investigation of a concern notified and dealt with in accordance with this Policy- these would be via the Health Boards HR procedures;

(f) A concern that is notified verbally and is resolved to the satisfaction of the person who notified the concern within 48 hours of the concern being notified;

(g) A concern with the same subject matter as a concern that was previously notified verbally and was resolved to the satisfaction of the person who notified the concern within 2 working day, unless the Health Board considers that it is reasonable to re-open the concern and undertake an investigation under this Policy;

(h) A concern previously considered under this Policy or the Health Board's previous Complaints Policy and Procedure;

(i) A concern that is/becomes the subject matter of Civil Proceedings. If court proceedings are issued when a concern is already under investigation in accordance with the regulations, all further investigation of the concern must stop;

(j) A concern that is/becomes the subject of a concern related to an Individual Patient Treatment Request.

(k) Police criminal investigation

(l) POVA's

The Health Board will advise the person who notified the concern, as soon as reasonably practicable, in writing, of the reason(s) for any decision that the concern is excluded from the scope of the Regulations and, thereby, this Policy. However, this written notification/justification is not required in relation to a concern that was notified verbally and resolved to the satisfaction of the person who notified the concern within 48 hours of the concern being notified.

9. TIME LIMITS FOR THE NOTIFICATION OF CONCERNS

A concern must be notified:

(a) within 12 months of the date on which the subject matter of the concern occurred, or

(b) within 12 months of the date on which the subject matter of the concern came to the notice of the patient. (Where a patient has opted to have a representative act on his/her behalf, this date is the patient's date of knowledge, NOT the date that the representative was informed of the concern by the patient).

To investigate a concern after this 12 month deadline the Health Board must consider whether the person raising the concern had good reason not to notify the Health Board of the concern

earlier and whether, given the time lapse, is it still possible to investigate the concern thoroughly and fairly.

However, a concern under these regulations **may not be notified 3 or more years after the date on which the subject matter occurred or after the date that the subject matter came to the notice of the patient**. The Health Board will, therefore, refuse to consider any such concern. (Where a patient has opted to have a representative act on his/her behalf, this date is the patient's date of knowledge, NOT the date that the representative was informed of the concern by the patient).If the person who raised the concern is a child at the time of injury the three year period does not begin to run until the individual reaches the age of 18years and runs out on their 21st birthday.

If the Health Board makes an exception to this it must make it clear to the person who raised the concern that the investigation may be limited in some aspects based on the information available as key staff may have left the Health Board and memory in relation to the circumstances will be poor.

10. WITHDRAWAL OF A CONCERN

A concern may be withdrawn at any time by the person who notified it. The withdrawal can be communicated to the Health Board by written, electronic or verbal means.

Where a withdrawal is communicated verbally, the Health Board is required to write to the person to confirm the withdrawal.

The Health Board can continue to investigate any concern that has been withdrawn, should it be considered reasonable and necessary to do so.

11. CONCERNS THAT INVOLVE OTHER ORGANISATIONS

Where the Health Board is notified of a concern that also involves the functions of another organisations, (whether this is known by the person notifying the concern or not), the Health Board is required to seek the consent of the person to contact any other relevant organisations and notify it of the concern. This consent must be sought within 2 working days of the receipt of the concern and done at the same time as acknowledging the concern. However they maybe occasions when it is not immediately evident that GP records need to be reviewed and comments sought

Once consent is received, the Health Board is required to contact all other relevant organisations involved in the concern within 2 working days of the consent being received.

All NHS Bodies involved in a concern are under a duty to co-operate to:

(a) co-ordinate the handling and investigation of the concern, and

(b) ensure that a co-ordinated response is provided to the person who notified the concern.

The Health Board must agree with the other organizations and person raising the concern which organization will take the lead, co-ordinate the investigation and provide the response. All relevant organizations should be included in any meetings arranged to discuss the concern.

12. CONCERNS NOTIFIED TO THE HEALTH BOARD INVOLVING PRIMARY CARE PROVIDERS

Regulations 18-21 deal with concerns notified about services provided by a primary care provider under a contract or arrangements with the Health Board.

When the Health Board receives a concern, notified by or on behalf of a person who is receiving or has received services from a Primary Care provider, it is necessary to determine whether it is appropriate for the Health Board to consider the concern or whether it is more appropriate for the concern to be considered by the Primary Care provider that is the subject of the concern. Before making this decision, and within 2 working days the Health Board must determine, from the person who notified the concern, whether:

(a) the concern has already been considered by the Primary Care provider, and if so, whether a response has been issued by the Primary Care provider that is in accordance with the requirements in the Regulations

(b) the person who notified the concern consents to details of the concern being sent to the Primary Care provider who is the subject of the concern.

If the concern has been investigated by the Primary Care provider and a response issued then the Health Board must not re-investigate it. The person must be advised of this and reminded of their right to take the matter to the Public Services Ombudsman for Wales.

If the concern has not been investigated by the Primary Care Provider and the Health Board considers this is a concern that it should investigate consent is required to allow the Health Board to send details of the concern to the relevant Primary Care provider who is subject of the concern. If consent is not provided the Health Board must not investigate the concern as it would not be possible to investigate without the co-operation of the Primary Care Practitioner, and the Practitioner should, in the interest of fairness know when a concern about them is being investigated.

If the Health Board decides that it is appropriate for it to deal with a concern, it is required to advise the person who notified the concern and the Primary Care provider of this decision within 5 working days, giving the reasons for this decision. Primary Care Providers are under an obligation to co-operate with investigations undertaken by the Health Board. However, the Health Board **may not** make any determination about the liability in tort of a Primary Care Provider. If such matters are alleged by the person raising the concern or arise during the investigation, the Primary Care Provider should be advised to involve their Medical Defense Organisation. The person raising the concern will need to be notified that the Health Board cannot become involved in those aspects of any concern about a Primary Care Provider.

If the Health Board decides that it is more appropriate for the concern to be dealt with by the Primary Care provider, the Health Board is required to advise the person who notified the concern and the Primary Care provider of this decision and why the decision has been made. The person raising this concern may be unhappy with this decision and should be informed as part of this decision letter of their right to take their concern to the Public Services Ombudsman for Wales.

When the Primary Care provider receives the notification of the Health Board's decision, the Primary Care provider must deal with the Concern in accordance with the Regulations.

13. HANDLING OF CONCERNS

13.1 Verbal Concerns / Complaints

Where a concern is notified verbally, the member of staff to whom the concern has been notified must make every effort to respond to that complaint there and then. If unable to do so to the satisfaction of the complainant they must escalate to someone more senior e.g. Ward Manager , On-call Manager, Departmental manager etc. All attempts should be made to deal with these issues as soon after they arise (taking no longer than 48 hours). These should be documented as informal concerns in the PALs module of Datix. Exceptions are Primary Care and Mental Health Learning Disabilities Service Units who do not have PALS teams.

If the complaint cannot be resolved to the satisfaction of the complainant then the person dealing with the complaint must make a WRITTEN record of the concern and PROVIDE A COPY of the written record to the person who notified the concern.

13.2 Acknowledgement of concerns

The Health Board must acknowledge receipt of the concern within **2 working days** of the day on which the concern is received.

The acknowledgement may be made in writing or electronically, depending upon how the concern was notified to the Health Board.

Where the concern was notified verbally, the Health Board is required to acknowledge the concern in writing, outlining what the issues were and what has been agreed in relation to matters for investigation.

For care & treatment concerns attempts should be made to contact the person who raised the concern to have a discussion with them prior to the acknowledgement going out to thank them in person for raising the concern, offer an apology that they have needed to do so, and offer a meeting with the manager of the area or clinicians responsible for services concerned. The written acknowledgement must confirm this and also include details in relation to who to contact in relation to the investigation being undertaken :

(a) the manner in which the Health Board will handle the investigation, including consent to the use of medical records;

(b) the availability of advocacy and support services that may be of assistance to the person in their pursuit of the concern;

(c) the period within which the Health Board is likely to complete the investigation of the concern and send a response to the person.

Further details on investigating and responding to concerns is provided in the Health Boards Concerns Procedure.

13.3 Consent

Where the patient has raised the concern then in doing so, they can be deemed to have given

implied consent to an investigation. This will also apply if a concern is raised by a representative who has shown proof that they are legally entitled to act for the patient/data subject (e.g. the representative has a Power of Attorney and the terms of the Power of Attorney have been met). However, in order for individuals to be clear in the knowledge that their medical records may need to be accessed, this should be explained in the acknowledgement letter so that they have the opportunity to indicate if they do not want their health records accessed.

Where a third party has raised a concern on behalf of someone else, then the patient or their representative will have to be asked to give written consent to access to medical records and the conduct of an investigation.

13.4 Timescales for Response:

Regulation 24 requires the Health Board to take all reasonable steps to send the response to the person who notified the Concern **within 30 working days, beginning on the day that the notification of the Concern was first received.** It is essential that from the outset that the investigating officer advises the person who raised the concern of the predicted timescale for a response. If the Health Board is unable to provide a response within 30 working days, the following actions are required:

(a) a written explanation setting out the reasons for the delay must be provided to the person who raised the concern, with estimation or anticipated date for completion of response and personalised to the complainant

(b) the response must be sent as soon as reasonably practicable, within 60 working days if possible. Responses should not be sent later than 6 months, from the day that the notification of the concern was first received.

If there are exceptional circumstances that prevent the Health Board adhering to the 6 month extended period for provision of the response, the Health Board must contact the person who notified the concern of the reasons for the delay and when the response may be expected.

13.5 Response

The Regulations require that the Health Board's written response to the concern are below in addition the Health Board expects responses to be values based

(a) summarise the nature and substance of the matter or matters raised in the concern;

(b) describe the investigation undertaken by the Health Board; specifically providing details under each aspect of the Regulatory requirements;

(c) contain copies of any expert opinions that the investigator(s) received during the investigation;

(d) contain a copy of any relevant medical records, where this is appropriate;

(e) where appropriate, contain an apology;

(f) identify what action, if any, the Health Board will take in light of the outcome of the investigation;

(g) contain information about the Health Board's consideration of any allegation that has or may

have been caused. Specifically, if the Health Board decides that there is no qualifying liability in tort, the reasons for this decision will be detailed

(h) contain details of the right to notify the concern to the Public Services Ombudsman for Wales with the relevant paragraph indicating 12 timescale for contacting Ombudsman , and Community Health Council Advocacy support details.

(i) offer the person notifying the concern the opportunity to discuss the contents of the response further;

(j) be signed by the Responsible Officer or a person to whom delegated responsibility has been given by the Responsible Officer.

Where the Concern includes an allegation that harm has or may have been caused, but the Health Board is of the view that there is no qualifying liability, the Health Board must detail the reasons for this view in the response. In essence the response must say: what went wrong, why it went wrong and what action will be taken to prevent it occurring in the future.

Where the investigation determines that a qualifying liability does or may exist then the redress requirements outlined below must be included.

13.6 Where a Qualifying Liability does or may exist (redress)

Regulation 26 requires that where the Health Board's investigation of a concern determines that a qualifying liability exists or may exist, it is required to determine whether or not an offer of Redress should be made.

To establish liability, the following elements must be met:

- That the Health Board had / has a duty of care to the person. A legal duty of care arises when the health care system accepts the patient.
- The duty of care has been breached i.e. the standard of care / treatment provided fell below the expected standard.
- Causation of damage. Did the healthcare provider's acts or omissions caused harm to the patient as a result of the breach of duty of care.

An offer of Redress may be made by the Health Board, in accordance with the Regulations, where it is established that a qualifying liability exists

When the Health Board's investigation determines that there is or there may be a qualifying liability, the Health Board is required to produce an interim report (if unable to provide a full final report that contains a redress offer) that:

(a) summarises the nature and substance of the matter or matters notified in the concern;

(b) describes the investigation undertaken by the Health Board;

(c) describes why the Health Board believes that there is, or there may be, a qualifying liability;

(d) provides a copy of any relevant medical records;

(e) explains the availability of access to legal advice, without charge, Legal Advice and Instruction of Medical Experts.

(f) explains the availability of advocacy and support services which may be of assistance;

(g) explains the procedure that the Health Board will follow to determine whether or not a qualifying liability exists and the procedure for making an offer of Redress, if such a qualifying liability is found to exist;

(h) confirms that, when prepared, a copy of the investigation report will be made available to the person who is seeking Redress;

(i) contains details of the right to notify the concern to the Public Services Ombudsman for Wales;

(j) offers the person who is seeking Redress the opportunity to discuss the contents of the Interim Report with a member of the Health Board

(k) is signed by the Responsible Officer or a person with delegated responsibility;

13.7 Form of Redress

Redress comprises of:

(a) the provision of a written apology;
(b) the provision of an explanation of events;
(c) the provision of a report on the action that has been, or will be, taken to prevent similar cases arising.
(d) the making of an offer of compensation in that the Health Board offers can take the form of entry into a contract to provide care/treatment or an offer of financial compensation, or both in respect of a qualifying liability up to £25,000.

If the Health Board considers that the qualifying liability justifies financial compensation exceeding £25,000, the Health Board must not offer Redress in the form of financial compensation under the Regulations. The Health Board may, however, make an offer of settlement outside of the provision of the Regulations.

The Health Board must assess and calculate damages for Pain, Suffering and Loss of Amenity on the Common Law basis. Welsh Ministers have issued a Compensation Tariff, which, the Health Board's legal team will apply when calculating financial compensation.

A patient, or his or her representative, has 6 months however they may be situations that this can be extended to 9 months, this is discretionary (from the date the offer is made) to respond to an offer of financial compensation made by the Health Board. After 6 months, the liability will no longer be considered as being the subject of an application for Redress.

In cases where the Health Board has decided that it considers there is no qualifying liability, and has decided not to make an offer of Redress, that liability will not be considered to be the subject of an application for Redress after 6 months from the date on which the Health Board communicated its decision.

Redress is not available, and must not be offered, in relation to a liability that is, or has been, the

subject of Civil Proceedings. If such Civil Proceedings are issued during the course of the Health Board considering Redress, the Health Board must cease all consideration of Redress and must advise the person who notified the Concern accordingly.

Legal advice and the Instruction of Medical Experts

When the Health Board determines that a qualifying liability exists, or may exist, it is necessary to ensure:

(a) that legal advice, free of charge, is available to the person seeking Redress

and

(b) if a medical expert or experts need to be instructed, that such instruction is carried out jointly by the Health Board and the person who has notified the Concern.

Legal advice must only be sought from firms of solicitors who have an expertise in the field of clinical negligence. Firms will be recognised as having the necessary expertise if they have at least one partner or employee who is a member of the Law Society Clinical Negligence Panel or the Action Against Medical Accidents Clinical Negligence Panel.

The free-of-charge legal advice, is to be made available in relation to:

(a) the joint instruction of medical experts, including seeking clarification from such experts on issues arising from their reports;

(b) any offer of financial compensation that the Health Board has made;

(c) any refusal by the Health Board to make such an offer; and

(d) any settlement agreement that is proposed.

The Health Board must bear the full cost of this legal advice and the costs arising from the instruction of the medical experts.

Reopened Complaints

In the event that a complainant is dissatisfied with their response and there are no new issues to investigate then the complaint will be reopened and reconsidered. A meeting with the complainant will be offered or further response issued. Where the complainant is happy with the response but raises new issues then a new complaint will be opened.

14. ENSURING A LEARNING AND SUPPORTIVE CULTURE

14.1 Learning from Concerns

The Health Board will ensure that it has arrangements in place to review the outcome of any Concern that has been subject to an investigation under the Regulations, in order to ensure that any deficiencies in its actions or its provision of services, identified during the investigation, are:

(a) Acted upon - where immediate action cannot be taken an action plan will be developed using the template action plan in Datix. All action plans will be recorded in Datix Action Plan module; and

(b) Monitored - by the Service Delivery Unit to ensure the actions are implemented timely and the action(s) taken are minimizing the risk of reoccurrence.

Learning lessons throughout the Health Board and taking action to ensure any necessary improvements are made is critical to avoid such deficiencies recurring.

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14.2 Supporting Staff

The Health Board promotes an open and fair culture where staff are supported and the emphasis will be on learning and taking action to avoid a reoccurrence. Where allegations are made that members of staff's behaviour included one of the following:

- involved a deliberate intent to harm
- was a flagrant disregard for the safety of patients or others (e.g. treating patients whilst under the influence of alcohol)
- forseeably placed the safety of patients at risk
- was a deliberately repeated breach of policy or procedures
- was a criminal act (e.g. assault)
- was a malicious act
- evidences repeated non-reporting of errors or violations
- evidences repeated failure to engage in learning lessons

The Health Board will utilise the 'Incident Decision Tree' tool, developed by the National Patient Safety Agency, to ensure appropriate and consistent decisions are made in this respect.

14.3 Being Open/ Duty of Candour

The Health Board requires that an open and transparent approach is taken in relation to all concern investigations. It is essential that Health Board staff are open and honest with patients and people who raise concerns. This will include the need to communicate with patients or their loved ones as soon as a harm incident comes to light and to maintain and open and honest dialogue throughout the investigation procedure and providing the patient / person who raised the concern with a full copy of any investigation report produced.

14.4 Confidentiality

Information contained within a reported/notified concern falls within the definition of personal data contained within the Data Protection Act 1998. The Health Board also has duties under the requirements of Caldicott and the Human Rights Act 1998 in respect of the right to privacy and also the Freedom of Information Act 2000 in respect of openness.

Information on individual reported/notified concerns should not be disclosed/copied/shown to any external agency without the permission of the Responsible Officer or nominated

deputies. All requests for access to such information should, therefore, be directed to the appropriate Manager, or nominated deputy, for the service area that is the subject of the concern, in the first instance.

15. MANAGING MEDIA INTEREST/MEDIA COMMUNICATIONS

The management of any media interests/communications in relation to incidents, either individually or generally, will be undertaken by the Health Board Communications Department based at Health Board Headquarters, Baglan.

16. TRAINING

All staff responsible for the management of complaints and concerns at all levels of the Health Board must have appropriate training. This will vary from customer care and nipping issues in the bud awareness on induction, to formal customer care & nipping issues in the bud training to full complaints and redress training days for managers.

Datix Web e – learning training should be undertaken by all staff who are required to use the Datix system.

Managers will identify training needs of individual members of staff through the performance review and PADR and make staff available to attend such training programmes.

Where an investigation of a concern reveals a training issue, the line manager will consider not only what actions should be taken to support the individual but also whether there is a need for wider training. Where this need is considered to extend beyond the local remit or there are implications for Health Board-wide training, Service Delivery Units should highlight this to the Quality and Safety Forum.

17. Disability and Special Requirements of a Complainant

At the outset when a complaint is made and a complainant identifies a disability or special requirements in relation to communication every effort must be made to make reasonable adjustments to accommodate the special request/requirement. Once agreed this should be documented in Datix and shared with all staff who will communicate with the individual.

18. DEALING WITH UNREASONABLE DEMANDS

People raising concerns have the right to be heard, understood and respected. On occasions there may be times when persons raising the concern out of character and become determined, forceful, and angry and make unreasonable demands of staff. The Health Board recognises that persons who complain despite being advised on other avenues available to them may also show aggression towards staff or continue to persistently pursue their concern by phoning, writing, or in person

Behaviours that escalate into actual or potential aggression towards staff are not acceptable.

What is unreasonable, unacceptable aggressive or abusive, violent behaviour?

Definitions

- Violence – behaviour that produces damaging or harmful effects, physically or emotionally on other people.
- Persistent unacceptable behaviour – behaviour that is deemed unacceptable within one event or on a number of occasions within a period of time.

Examples of unacceptable aggressive or abusive behaviour –

- Verbal threats unsubstantiated allegations or offensive statements can also be termed as abusive violent behaviour.
- Threatening remarks e.g. both written and oral.
- Unreasonable demands e.g. Demands for responses within unrealistic timescales, repeatedly phoning, writing or insisting on speaking to particular members of staff.

18. DEALING WITH UNACCEPTABLE ACTIONS OR BEHAVIOUR

If staff encounters situations where person behave in an unacceptable manner towards staff appropriate action should be taken in line with The Health Board policies and procedures. If the person raising the concern becomes aggressive or abusive consideration should be given to the following actions:

a. Threats or physical violence to staff should be reported to the police. An Anti Social Behaviour Referrals completed (An anti social behaviour is summarised under the Crime and Disorder Act as "where a person has acted in a manner that caused or was likely to cause harassment, alarm, or distress.

b. An incident form should also be completed and recorded on the Datix Incident system

c. Correspondence if received is deemed to be abusive and contains threats to staff or the organisation this must be reported to a Senior Manager /police. If unsubstantiated allegations are received then the person should be told that the language used is unnecessary and unhelpful. It should be made clear that if the behaviour and use of language continues all forms of communication will stop.

d. If a person is aggressive, abusive or offensive whilst on the telephone the person should be informed that their behaviour is unacceptable and if it continues the telephone call will be terminated (please refer to telephone aggression training provided).

19. DEALING WITH ABUSIVE BEHAVIOUR BY TELEPHONE

Abusive behaviour by telephone is no more acceptable that it is in person and should not be tolerated. Sometimes a caller may be expressing frustration at their own situation and it is not meant to be directed personally at the staff member receiving the call. Although the tone of the conversation may initially be unacceptable, staff may feel that they can overcome this by reasoning with the caller .There may be occasions when the caller is beyond reason and no amount of understanding and concern will have any effect on their conduct, The staff member should interrupt the conversation at an opportune moment and state clearly that the tone and content is unacceptable and request the caller modify it accordingly. If this is not heeded the caller must then be told if they continue the call will be terminated. If the caller does not comply

with the request the member of staff should inform the person that the call is to be terminated and do so immediately. An incident form should be completed. The incident should be reported to a senior staff member.

Support
Following the incident the staff member involved should have a de-briefing session with a senior staff member to ascertain if further input is required to support the staff member.

Capacity
The Mental Capacity Act 2005 states that the starting assumption must always be that a person has the capacity to make a decision, unless it can be established that they lack capacity. A person is unable to make a decision if they cannot:

- Understand information about the decision to be made (relevant information);
- Retain that information in their mind;
- Use or weigh that information as part of the decision making process or communicate their decision (by talking, using sign language or any other means).

20. MANAGING PERSISTENT BEHAVIOUR

If a person repeatedly telephones, visits, or writes raising a concern which has already been investigated and a response sent then consideration should be made for:

a. Putting arrangements in place whereby calls can only be received from them at set times on set days;

b. One staff member is allocated as a point of contact for written or verbal communication;

c. Restrict contact to written correspondence only;

d. If it is necessary to meet with the complainant as all other options have been explored , the **meeting should never be undertaken alone**;

e. Communication that no further correspondence or telephone call will be responded to unless new issues are raised , and any correspondence will only be acknowledged;

f. In extreme cases legal advice should be sought.

Importantly each stage it should be made clear to the person what actions are being taken and why

Appendix 1

Managing and Reporting Patient Safety Incidents

1. General

Not everything that happens is a reportable patient safety incident. For example, patients are admitted to hospital and despite care, they may suffer a natural event, with no failing apparent. In these circumstances. Such an occurrence is not a reportable patient safety incident unless it is considered that there may have been or there was some untoward contributory factor - for example, it might have been possible to resuscitate the patient following the arrest, but staff were unable to do so because the defibrillator was defective.

If staff are uncertain, they should discuss the issue with their Line Manager or the Units Quality and Safety Team for advice

An incident report should not be completed where staff wish to register a point of view or highlight that a situation is less than ideal. There are other, more appropriate, means of raising and dealing with such situations, which would include risk assessment. The Health Board also has other policies that may be the more appropriate avenue for raising a Concern e.g. the Whistle Blowing Policy, the Grievance Policy and Procedure. In the event that a member of staff is unsure whether an occurrence meets the definition of a reportable patient safety incident, this should be discussed with the line manager, with escalation through the Unit, Professional Leads etc., as necessary. Alternatively, staff can contact the Patient Feedback Team at HQ for initial advice.

2. Definitions

Patient Safety Incident

Any unexpected or unintended incident, which did lead to harm for a patient or could have led to harm for a patient.

This definition includes any unexpected or unintended incident, which could have led to harm but when that harm was prevented by way of some intervention.

Harm

Harm is considered to be any injury (physical or psychological), disease, suffering, disability, impairment of normal function or death.

Harm should be viewed from the patient's perspective.

The definitions of the various grades of Harm are detailed in the Grading of Concern section .

2. THE IMMEDIATE MANAGEMENT OF INCIDENTS

Notifications/Initial Contacts

Each Service Delivery Unit should define its specific arrangements for ensuring compliance with the following requirements and communicate these to all staff.

Incidents occurring within normal working hours (Monday-Friday, 09.00 – 17.00)

The senior person on duty should be informed of the any patient safety incident.

In the event of a serious (Red) incident, the senior person at the scene should inform the relevant/nominated member of the Unit, by telephone, of the situation and the actions taken so far and follow the Management of Serious Incidents Procedure

Incidents occurring outside normal working hours

The senior person taking responsibility at the scene must notify the On-Call Manager of the Incident and the action being taken.

Responding To The Immediate Needs Of The Persons Involved

Ensure the immediate safety and care of the patient involved. Where the patient has sustained an injury, an appropriate level of examination and treatment must be offered. If the patient is not an inpatient, this might include referral to A&E. Refusal of that offer should be noted in the incident report.

If the Incident in any way relates to the use of medical equipment, disconnect the equipment from the patient and refer to section on medical devices.

The consultant or lead professional in charge of the patient's care must be informed, who should consider the communications with the patient/relatives/carers at this time.

If the Incident occurs in a community setting, and it is considered that the GP should be made aware, the patient should be advised to contact the GP, or the member of staff should personally notify the GP as soon as practicable after the incident. If the incident is sufficiently serious, the GP should be notified immediately and/or an ambulance should be called.

Re-Establishing A Safe Environment

Appropriate action must be taken to contain the situation, as agreed with the contact person/senior person on duty. There should be notification to or advice sought from specialist advisors/departments, as necessary (e.g. Infection Control, Pharmacy etc).

Preservation of Evidence

It is important that there is a common sense approach and that there is discussion within the Unit or with relevant specialists in any given situation.

Where it is suspected that drugs may be defective/contaminated/out of date etc, they **must** be taken out of use and contact made with Pharmacy for advice.

If the incident is serious (Red), all the relevant evidence must be preserved and kept secure. There may be a police investigation as well as a Health Board investigation. If necessary, secure the area, to ensure that everything is left untouched. Lock doors and put up signs clearly stating that no-one is permitted to enter the area. Explain the reason for the closure to patients, relatives, visitors and staff in the vicinity, ensuring that confidentiality is not breached.

If the Incident involves the use of **medical equipment**, the item(s) of equipment must be removed from use, appropriately labelled and retained for inspection by the Medical Equipment Management Service (EBME/Medical Electronics) or other specialist departments. All accessories and disposables/consumables must be retained intact. Settings must not be

adjusted. The equipment must be clearly labelled as 'Evidence - Not To Be Used' and it must be stored in a place and manner such that it cannot be accidentally or intentionally brought back into use until all investigations are complete and formal approval has been given for the re-introduction of the item. The supplier or manufacturer of an item should **not** be contacted at this particular time.

If the Incident involves the use of **non-medical equipment**, it must be removed from use, appropriately labelled and retained for inspection by Estates or IT. All accessories and disposables/consumables must be retained intact. Settings must not be adjusted. The equipment must be clearly labelled as 'Evidence - Not To Be Used' and it must be stored in a place and manner such that it cannot be accidentally or intentionally brought back into use in the intervening period until all investigations are complete and formal approval has been given for the re-introduction of the item. The supplier or manufacturer of an item should **not** be contacted at this particular time.

Equipment must be decontaminated/cleaned in accordance with relevant Health Board procedures, to ensure that it does not present a biological hazard to staff inspecting or repairing it. Where decontamination/cleaning would destroy vital evidence, the item should be placed in protective containment, labelled, and placed in a secure location

There must be very good reason if any equipment involved in the incident is not to be removed from use. A discussion with the senior manager in charge, relevant specialist department and the Patient Feedback Team will be necessary before such a decision is taken. Where an item is not removed from use, a full and accurate description of the state of the device at the time must be recorded and photographs taken.

Once investigations are complete, should any equipment be identified as requiring service or repair, a works requisition must be submitted as a matter of urgency or any other necessary action taken but it is vitally important that a photograph of the equipment be taken prior to repair taking place.

Advice can be sought from specialist departments or the Patient Feedback Team if it is considered that photographs of the environment/facility are necessary or would be helpful.

3. REPORTING PATIENT SAFETY INCIDENTS (WITHIN THE HEALTH BOARD)

Reporting serious (Red) patient safety incidents

If the incident concerns more than one Unit, the nominated senior person notified of the incident should make contact with each and a lead Unit should be agreed.

The nominated Unit senior person should inform the Chief Operating Officer of the incident.

The Chief Operating Officer will inform the remaining members of the Executive Team and the Chief Executive. A decision will be made on whether the incident requires instigation of the Major Incident Procedure. If this is considered necessary, suitable arrangements will be made to inform the Chairman, Assistant Director of Nursing, & Patient Experience and Deputy Medical Director.

Additionally, an automated email trigger has been established within the on-line incident reporting system that will inform the Assistant Director of Nursing and Patient Experience, the Assistant Medical Director, and the Serious Incident Team of any serious (Red) patient safety incidents at the time of reporting. If this is the first notification of the matter within the Health Board, all appropriate notifications to the Executive Team will be instigated at this time.

Completing the on-line incident report

Incidents are to be reported using the on-line incident reporting facility. This is accessible from the Health Board intranet.

A guide for all staff, on how to use the online incident report form, is accessible from the same location.

Where/if there are exceptional operational circumstances that present difficulties in accessing the intranet and, therefore, the online reporting facility, the Unit must specify the arrangements for its staff for the initial capture of the incident information. It must also specify its arrangements for how it will ensure that information is then reported using the on-line incident reporting facility.

The on-line incident report must be completed within **3 working days** of the occurrence of the incident.

If the matter is serious (Red), the on-line incident report must be completed **within 24 hours** of the occurrence.

As far as possible, the person most directly involved in the patient safety incident should complete the incident report.

Witnesses to a patient safety incident

The Witness Report Form (IR2) is available from the Intranet.

Any witnesses to a patient safety incident should complete a Witness Report (IR2), on which they should record the facts of what they witnessed.

Any Witness Report(s) (IR2) can be attached as a 'Document' to the on-line incident report, by the incident reporter. If a Witness Report is not yet available at the time of completing the on-line incident report, it should be attached to the incident record in the Datix system, when it is available, in accordance with the arrangements defined by the Unit.

Witnesses should be reminded that no allegations are being made against them and that the purpose of providing a report is simply to obtain factual information that could be of assistance in establishing the facts leading up to the incident.

A Witness Report or a formal statement may also be requested later, as part of an investigation of a patient safety incident.

4. GRADING CONCERNS THAT ARE PATIENT SAFETY INCIDENTS

There are common features in the Grading process and matrix for all types of Concerns. Specifically, the Table of Consequences is common. However, as far as patient safety incidents are concerned, there are two Grades to be determined, as follows, and it is the HIGHER of these that determines the nature and scale of investigation required and the reporting requirements.

1. the actual outcome/consequences of the patient safety incident (SEVERITY)
2. assessment of future risk potential (FUTURE RISK GRADE)

The reporter of a patient safety incident will make a judgement on both Severity and Future Risk Grade at the time of reporting, using the Grading Matrix and Tables in the Risk Management Framework.

The assessment of either Severity or Future Risk Grade should not delay completion/submission of the incident report. The reporter should make the most reasonable assessment possible based on the information available at the time. There is always scope for re-grading the incident, if necessary, as facts and issues emerge. An incident Grading can also be re-examined at the time when the risk reduction options are determined. This will also assist in prioritising the actions planned.

Grading Actual Outcome (Severity)

Actual Outcome (Severity) = the actual or apparent outcome/harm/impact of the incident. Harm includes psychological harm as well as physical harm.

The actual or apparent outcome has to be mapped against the Outcome (Consequences) Table in order to determine the relevant descriptor. Once chosen in the On-line incident form, the relevant colour code for the Grade will automatically be allocated.

Grading Future Risk Potential

There are three steps involved in determining the Future Risk Potential.

Step 1:

- Assess the likelihood of the incident happening again in the Health Board and map against the descriptors in the Likelihood Table.

Step 2:

- Assess what the **most likely** outcome would be if the incident were to re-occur and map against the Outcome (Consequences) Table.

Step 3:

- The answers obtained in Steps 1 and 2 are plotted on the Future Risk Matrix in the On-line incident form, which determines the overall risk score and Grade for a potential future incident.

Reporters and Reviewers involved in grading Future Risk Potential need to think about the patient safety incident that has just occurred and the circumstances surrounding it. Was the outcome a 'lucky outcome' today? Could the outcome realistically have been much worse? If the Incident should happen again, how might people realistically be affected? What potential implications would there be in terms of resources, cost, relations with the public etc? The Outcome (Consequences) Table helps to map the answers to these questions. Each of the columns must be considered and a decision made on the **most realistic scenario** if the Incident should re-occur.

Additionally, when incidents are assessed for Future Risk Potential, the *status quo* must be maintained in terms of circumstances, i.e. the same type of patient, in the same place, at the same time, in the same circumstances. Also, the assessment cannot take account of any additional risk control actions over and above those that are already in place.

Risk Matrix

Step 1 – Measure of Consequence

The envisaged or actual consequences and likelihood are analysed in the context of any risk controls that have already been put into place using Table 1. It is acknowledged that in practice, both Steps 1 and 2 are subjective and will depend on the knowledge and expertise of the person(s) involved in the risk assessment process. To mitigate this, risk assessment is most appropriately conducted as a group/multidisciplinary activity.

Descriptor	Actual or potential unintended impact on individual(s) - Patient, family member, visitor, contractor, staff	Actual or potential impact on the Health Board
1 NEGLIGIBLE Green	No harm, harm prevented or very minor harm. **Example(s):** Cut or bruise. First-aid treatment only required. Some extra observation required. Unsatisfactory patient experience not related to patient care.	No damage or very minor damage. No direct financial loss or financial loss up to 1k Very minimal impact. No service disruption. **Example(s):** Wastepaper basket fire
2 MINOR Yellow	Avoidable short-term, non-permanent harm or impairment of health – full recovery in up to 1 month. **Example(s):** Minor healthcare associated infection. Temporary avoidable increase in pain experience. Unsatisfactory patient experience – readily resolvable	Short-term damage, remedial within 1 month. Increased length of hospital stay/level of care – between 1 and 7 days. Single failure to meet internal quality standards. Damage or direct financial loss up to £10,000. Staff sickness < 3 days. Low risk of complaint.
3 MODERATE Amber	Avoidable semi-permanent injury or impairment of health or damage - recovery in up to 1 year. Additional interventions required or treatment needed to be cancelled. Necessary to transfer to another centre for treatment/care. **Example(s):** Temporary loss of mobility Temporary loss of vision Healthcare associated infection taking up to 1 year to resolve e.g. MRSA Further/new surgical intervention required Mismanagement of patient care	Damage remedial in up to 1 year. Direct financial loss/cost up to £100,000. Increased length of hospital stay/increased level of care – 8 to 15 days. Temporary restrictions on service(s) / service disruption. Repeated failures to meet internal quality standards. Staff sickness > 3 days. Local adverse publicity / moderate loss of confidence in organisation. Risk of litigation with cost up to £500,000. MHRA Reportable. Mental Health Act Commission Assessment. HSE Improvement Notice issued.
4 SEVERE Red	Irrecoverable injury or impairment of health, having a lifelong adverse effect on lifestyle, quality of life, physical and mental well being. **Example(s)/including:** Procedures involving wrong patient/ body part. Loss of major body part(s). Retained instrument/material after surgery. Healthcare associated infection, which may result in major permanent harm e.g. Hepatitis C. Haemolytic transfusion reaction. Radiation dose much greate/less than intended, whilst undergoing a medical exposure. Mis-diagnosis with poor prognosis of return to health Infant abduction or discharge to the wrong family. Serious concerns re patient experience or clinical service requiring escalation to executive level for investigation/action.	Adverse national publicity. Loss of confidence in the Health Board. Ability of Health Board to provide a service adversely affected / temporary service closure/resources needed to remedy situation – up to £1M. Increased length of stay or care over 15 days. Risk of litigation with cost up to £1M. Prohibition Notice / Executive Officer fined. Failure to meet national and professional standards of quality. **Example(s):** Trust-wide PAS/PIMs failure.
5 MAJOR Red	Avoidable loss of life or unnecessary shortening of life expectancy. **Example(s)/including:** Unexpected death of a patient whilst under the direct care of a healthcare professional. Healthcare associated infection resulting in or with potential to result in death, e.g. hospital acquired legionellosis. Suicide or homicide committed by a patient being treated for a mental health condition. Unacceptable patient experience which would lead to an investigation by external bodies eg Mid Staffordshire	Significant adverse national / international publicity. Severe loss of confidence in the Health Board. Extended service closure. Risk of litigation with cost over £1M. Criminal prosecution. Direct financial cost over £1M. **Example(s):** Major loss of healthcare facilities due to fire. Loss/destruction of medical records department and all patient records Screening errors and failure to recall.

Step 2 – Measure of Likelihood

Table 2

Level and Descriptor	Description	Example
1 RARE	Would only occur/reoccur in very exceptional circumstances; considered a very remote probability that it could happen / happen again.	10 Yearly
2 UNLIKELY	Not expected to occur/reoccur but there is some possibility.	Yearly
3 POSSIBLE	May occur/reoccur at some time / occasionally.	Monthly
4 PROBABLE	Will probably occur/reoccur but will not be a persistent issue.	Weekly
5 EXPECTED	Will occur/reoccur and likely to be frequent.	Daily

Step 3 Risk Rating

Multiply the consequence and likelihood together to provide the Risk Rating which determines the overall risk ranking and priority of the risk for action (risk treatments), in accordance with the Risk Matrix:

Risk Matrix	LIKELIHOOD				
CONSEQUENCES	1 Rare	2 Unlikely	3 Possible	4 Probable	5 Expected
1 Negligible	1	2	3	4	5
2 Minor	2	4	6	8	10
3 Moderate	3	6	9	12	15
4 Major	4	8	12	16	20
5 Critical	5	10	15	20	25

1 - 4 LOW	This level of risk is considered acceptable and no additional action is required over and above existing management measures.
5 - 8 Manageable	This level of risk is marginally acceptable and efforts should be made to reduce the risk although the costs of reduction must be carefully considered. Risk reduction actions should be completed within 12 months.
9 - 15 Amber Moderate	This level of risk should be discussed and actions agreed by the Service Delivery Unit. Action to reduce the risk should be completed in 6 months.
16 - 25 HIGH	Board level notification/attention of this level of risk is required, via the Quality and Safety Forum. Urgent attention to the risk is required by the Unit with actions to reduce the risk commencing within 1 month. Close monitoring required. Immediate action may be required, including halting the process although before doing so the risk must be assessed to ensure it is safe to do so..

4. ACKNOWLEDGEMENT OF A PATIENT SAFETY INCIDENT REPORT

On clicking the 'Submit' button, the reporter of the incident will receive an instant, on screen, acknowledgement of the incident report having been received.

The reporter will receive feedback following conclusion of the investigation and closure of the incident which will be sent to the e-mail address provided.

5. REVIEWING THE INCIDENT REPORT

The purpose of the review is to:

- Ensure that the matter reported constitutes a reportable patient safety incident.
- Ensure that all the information is accurate and comprehensive.
- Ensure that all appropriate actions in response to the incident have been taken or are underway. This includes commissioning an appropriate investigation.
- Ensure that all appropriate communications are undertaken.
- Ensure that appropriate and timely feedback is provided to the incident reporter.

The full details of the actions required of Reviewers are provided on the intranet.

The review and approval/rejection of the patient safety incident must occur within **3 working days** of the date that the incident is reported.

The reviewer should ensure that any person who is directly involved in the incident is informed of the report, either directly or through his/her manager, as is deemed most appropriate. If the reviewer believes that this action should not be taken, the reasons for this decision must be fully documented in the Datix record. Advice can be sought from the Patient Feedback Team, if necessary.

Staff involved in patient safety incidents may require assistance and support. What is appropriate is likely to depend on the nature of what has happened and the outcome. Some areas may be covered by particular policies, such as the Inoculation Injury Policy. The Reviewer of the incident report will need to consider the involvement of and advice from appropriate persons and departments including the Unit Management Team, Professional Leads, Executive Directors, Personnel, and Occupational Health Department etc.

Reviewing serious (Red) incident reports

The Serious Incident Team will review the incident report and make contact with the relevant Directorate/Locality to discuss and agree all necessary actions.

6. BEING OPEN

Where a patient safety incident is notified by a member of staff and the Reviewer of the incident is satisfied that the patient has suffered or is likely to have suffered **Moderate or Severe harm or death as a consequence of that incident**, the Health Board is required to:

(a) notify the patient or his/her representative of the patient safety incident, and
(b) involve the patient, or his/her representative, in the investigation of the patient safety incident.

The Being Open process must be formally commenced and followed by the Unit.

This process will govern all communications with the patient/representative.

Where the Reviewer of the patient safety incident has cause to believe that it would not be in the interests of the patient to be informed of the patient safety incident or involved in the investigation, the Reviewer must

- make a written record of this decision and the reasons for it against the Datix record, and
- keep the decision under review during the investigation of the patient safety incident and act in accordance with the Being Open process if the decision should change.

7. EXTERNAL REPORTING

Specific requirements for serious (Red) Incidents

Welsh Government – Improving Patient Safety Team

All such incidents must be reported to the WG Patient Safety Team in accordance with the requirements specified by that team. The Serious Incident Team will ensure these incidents are reported and updates provided. This is covered in more detail the following management protocols:

- Serious Incident/No Surprise Report Reporting – Appendix 2;
- Serious Incident Team Investigation – Appendix 3 and;
- Never Event Incident Management – Appendix 4.

Health Commission Wales

Serious patient safety incidents involving Forensic Psychiatry should be reported to Health Commission Wales at the same time as they are reported to WG. This should be done by a nominated person within the Mental Health Directorate.

Health & Safety Executive

The Head of Health & Safety will consider any necessity to make contact with the Health and Safety Executive and will inform the Executive Team accordingly.

Police

The Chief Executive and Executive Team will decide whether the Police should be notified of the incident and instigate the necessary actions.

Requirements for specific types of incidents

A number of external organisations/agencies must be contacted when a particular type of Incident has occurred. The following section lists these organisations and gives brief information on the mechanisms for reporting.

NHS Partners, Tertiary and Specialist Providers/Contractors, Social Services, Local Authority Departments

Except where other specific arrangements or requirements may exist, the Executive Team will consider and agree the level and nature of communications in respect of

any individual, patient safety incident and the extent of any involvement of such partners/stakeholders in the overall Incident management and learning process.

Incidents involving ionising radiation

The Ionising Radiation Regulations 1999 specify reporting requirements for a range of incidents including loss of radioactive sources and equipment faults resulting in a patient exposure 'much greater than intended. The reporting arrangements for incidents involving medical exposures are included in the Health Board Ionising Radiation Safety Policy, Corporate Procedure C and Appendix 16. Incidents involving exposure of patients to ionising radiation to an extent which is 'much greater than intended' will be reported to HIW via the Medical Director on the advice of the Radiation Protection Adviser.

Drug Reactions and Medicine Defects

These incidents need to be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA).

The reporting of any suspected drug reaction can be made by any professional member of staff using the Yellow Card system for reporting, which can be found on the back page of the BNF. The person making the report should also advise the Chief Pharmacist, who will consider whether a Health Board incident report needs to be completed and submitted.

Medicine defects, such as cloudiness of liquid or discoloration of medicines, should be reported to the Chief Pharmacist who will advise the all Wales Medicines Quality Controller and complete an Incident Report if appropriate.

Medical Devices and Equipment

These incidents need to be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA).

Where any Incident relates to/involves the use of medical equipment, there should be contact with the Nominated Device Specialist who will advise on or assist with the investigation of the incident, as appropriate and make a report to the MHRA, if required.

Communicable Diseases and Inoculation Injuries

The Infection Control team will report notifiable Incidents to the Centre for Communicable Disease Control and will undertake EPINET reporting for inoculation injuries.

Serious Hazards of Transfusion (SHOT)

This is a voluntary reporting scheme to which the Health Board submits reports of relevant incidents. Automated email triggers from the on-line reporting system will alert the Blood Transfusion Practitioners of any such reported incidents.

Incidents involving the death of a patient detained under the Mental Health Act or the discovery of unlawful detention

The Mental Health Directorate will report Incidents involving the death of a patient detained under the Mental Health Act or the discovery of unlawful detention to the Mental Health Act Commission, by telephone, during office hours on the same day or first thing the following day.

Safeguarding Adults

Under the Protection of Vulnerable Adults (POVA) process, cases are led by a Designated Lead Manager (Head of Nursing or nominated deputy) and as such the DLM must notify Social Services and South Wales Police of all POVA incidents, as identified in the Inter Agency Policy & Procedures for Responding to Alleged Abuse and Inappropriate Care of Vulnerable Adults in South Wales and the ABM Health Board Adult Safeguarding Policy.

Safeguarding Children

The Named Child Protection Health Professionals will report on Child Protection incidents, in accordance with the all-Wales procedures.

All patient safety incidents - National Reporting and Learning System (NRLS)

All NHS organisations are required to report patient safety (with certain exceptions) to the NRLS via an electronic export of data from the Datix System. This task will be undertaken by the by the Datix Team on a weekly basis.

ADDITIONAL RECORD-KEEPING REQUIREMENTS

A record of a patient safety incident should be written in the patient's clinical notes in addition to completion of an incident report. The incident report itself does not form any part of the patient's record and it should not be printed and filed in the patient's clinical notes.

When an inpatient has been the subject of a patient safety incident, the discharge letter sent to the patient's GP should contain summary details of:

- the nature of the incident and the continuing care and treatment
- the current condition of the patient
- key investigations
- recent results
- prognosis

Where a patient safety incident has occurred in the primary care setting that has resulted in an admission/referral to hospital, it may be expected that letter sent from the GP should contain summary details of:

- the nature of the incident
- the current condition of the patient
- any medical tests/investigations
- any immediate treatment given.

CLAIMS MANAGEMENT POLICY

Clinical Negligence
and
Personal Injury

Approved by	Date	Review Date
Assurance & Learning Group	November 2017	November 2020
Board		

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1. POLICY STATEMENT

1.1 This document describes the Policy of the Abertawe Bro Morgannwg University Health Board ("UHB") for the management of clinical negligence and personal injury claims made against the Health Board.

1.2 Both the human costs of things going wrong and the financial costs of providing redress are powerful incentives for effective risk management. It is acknowledged that funds that are spent on addressing and compensating could otherwise contribute to the continuous improvements of healthcare services and working environments. Therefore, this Policy forms an integral part of the Health Board's Risk Management Strategy and is intrinsically linked into the Health Board's systems for managing and learning from incidents and concerns.

1.3 The Health Board aims to deal with all claims made against it proactively, in an equitable, efficient and timely manner. In accordance with the Civil Procedure Rules 1999, the Health Board will deal with each case on its own merits, taking advice from its legal advisors and others, as appropriate.

1.4 The Health Board will adopt a common and standardised approach in dealing with litigation claims for both clinical negligence and personal injury. The Health Board aims to gather all evidence as quickly as possible and, where liability is admitted, will seek to negotiate settlement in the shortest possible time.

1.5 The Health Board will make every effort to resolve a claim before the issue of court proceedings and will explore the option of alternative dispute resolution methods when appropriate. Where formal legal action or Court proceedings are unavoidable, the Health Board will ensure that it conducts its defence of the Claim in a fair and timely manner, ensuring that legal costs are incurred appropriately and proportionately.

1.6 The Health Board acknowledges the importance of the claims management process within its organisation and will ensure that the process and the appointed Claims Manager has sufficient seniority and profile as required by WHC(97)17 and the Putting Things Right Guidance (2013) Part 8. The Health Board and relevant nominated committees will support and promote these objectives including the provision of support through an approved escalation procedure set out in the Health Board's Claims Management Procedure.

1.7 The Health Board will comply with the Pre-Action Protocols laid down by the Civil Procedure Rules in dealing with all legal claims ensuring a constructive and open approach to claims that reduces delays and costs and the need for formal legal proceedings.

1.8 The Health Board is committed to learning lessons from claims to ensure the continued improvement in standards of patient and staff safety and services.

The Legal Services Managers/Officers will support the Directors, key managers and staff in this process through the provision of claims information, which will assist in ensuring that lessons are learned and appropriate corrective and/ or preventive action is taken and implemented in an effective manner.

2. INTRODUCTION

2.1 Welsh Health Circular 2000(04) sets out that Welsh NHS bodies are not permitted to purchase commercial insurance and that the Welsh Risk Pool will cover risks arising from core activities with the exception of motor insurance, PFI and income generation. The Welsh Risk Pool is the risk pooling scheme run for the benefit of members of NHS Wales and it is funded through the Welsh Assembly Government by a top slicing arrangement. Further guidance on the extent of the WRP indemnity is provided within WHC (2000) 12. All successful claims submitted for reimbursement will be subject to an excess, currently £25,000. This Policy has been produced in accordance with the references contained in Appendix 1 for the management of the types of claims that do not arise from contractual obligation, in particular;

- clinical negligence claims;
- personal injury claims;
- losses and compensation claims (bad debts, losses, damage to/or loss of personal belongings through no fault of the individual).

The Policy does not apply to claims for reimbursement from the Pool relating to damage to Health Board property, claims under the Human Rights Act 1998, claims for unlawful imprisonment arising from the activities of Mental Health services and employment issues.

2.2 The Health Board has a legal duty of care towards those it treats, together with members of the general public and its staff. People who consider they have suffered harm from a breach of this duty can make a claim for compensation and damages against the Health Board.

2.3 For a claim to be successful, a claimant must prove:

- that he/she was owed a duty of care;
- that the duty was breached;
- that the breach of duty caused, or materially contributed to the harm caused; and
- that there were consequences and effects of the harm.

If a claim is successful, then the injured person has a right to compensation for that harm, the amount of which is assessed in accordance with the principles of common law and statute.

2.4 The Limitation Act 1980 requires that claims be made within three years of the date of the incident or three years from the date a claimant became aware that he/she had suffered from an episode of negligence. With minors, the

three-year limitation period becomes effective once they have reached the age of 18. However, there are no time limits for people with a disability who cannot manage their own affairs. Claims exceeding the three-year limitation period can, however, still be brought against the Health Board at the discretion of the Court.

2.5 The management and settlement of claims is often an expensive, lengthy and complex process and was examined by Lord Woolf so that improvements could be achieved in the overall civil justice system. This policy and associated procedures have been developed to mirror the objectives of openness and timeliness stressed by Lord Woolf in the introduction of the reforms to the Civil Justice System introduced in April 1999.

3. DEFINITIONS

The definitions for clinical negligence and personal injury negligence are:

3.1 Clinical/Medical Negligence

"*A breach of duty of care by members of the health care professions employed by NHS bodies or by others consequent on decisions or judgements made by members of those professions acting in their professional capacity in the course of employment and which are admitted as negligent by the employer or are determined as such through the legal process."*

3.2 Personal Injury

"Any disease or impairment of a person's physical or mental health condition."

4. RESPONSIBILITY FOR CLAIMS/SCOPE OF POLICY

4.1 Subject to the provisions of the Limitation Act 1980, the Health Board will be responsible for managing all claims arising from Secondary Care services, GP Out of Hours Services, nursing and medical services provided to HMP Swansea and Health Board managed GP services and Trainee Dental Unit which are currently under its management.

4.2 Claims arising from the treatment provided by contracted practitioners are not indemnified and do not form part of the Welsh Risk Pool Scheme.

4.3 From November 2013 claims arising from the treatment provided by sessional GPs within the scope of the NHS indemnity will be managed by the Health Board.

4.4 The Health Board will comply with the requirements of the Welsh Risk Pool in notifying other organisations and bodies of claims arising from service provision prior to the formation of the previous Bro Morgannwg and Swansea NHS Trusts but will retain day to day management of such claims unless

instructed otherwise. However, the Health Board has no delegated authority to make admissions of liability in respect of such claims or authorise payments of damages or costs. In accordance with the Claims Procedure and the relevant WRP guidance, liaison will take place with Powys Teaching Health Board or their nominated claims handlers to ensure appropriate authorities and reimbursement of outlay is obtained.

5. ROLES AND RESPONSIBILITIES

5.1 The **Chief Executive** has overall responsibility for claims management and will ensure there is a designated Executive Director with clear responsibility for claims management issues.

5.2 The **Medical Director** is the designated Executive Director with responsibility for claims management issues and will ensure effective management of claims within the Health Board and will keep the Board informed of all significant issues pertaining to claims.

5.3 The **Medical Director and Director of Nursing and Patient Experience** has joint responsibility for ensuring lessons are learned from settled claims and quality and safety. They will provide leadership and support in achieving the aims of this policy.

5.4 The **Head of Patient Experience, Risk and Legal Services** will be responsible for the control and administration of the entire Datix database/ensuring its consistent use across all modules (Incidents, Complaint, Claims, Risk Management and Patient Experience) for purposes of learning lessons and monitoring action plans, and any further responsibilities that will be more fully described in the Claims Management Procedure.

5.5 The Health Board is committed to employing a dedicated **Claims Manager** who holds or who is working towards relevant qualifications in claims management and who can demonstrate sufficient experience in the management of clinical negligence and personal injury claims. The identity and full responsibilities of this individual will be set out more fully in the Claims Management Procedure but as a minimum:

- Will be required to demonstrate on-going updating and continuing professional development in the area of claims management.

- Be responsible for implementing this policy corporately and will be given sufficient profile and seniority within the Health Board to achieve the objectives of WHC(97)17.

- The Claims Manager is the Lead Officer for the Welsh Risk Management Standard for Claims Management and is responsible for self-assessment against these standards.

- For the purpose of this policy the **Head of Patient Experience, Risk and Legal Services** is the dedicated **Claims Manager**, who delegates day to day responsibility of the claims to the Deputy Head of Risk and Legal Services.

5.6 **Locality Directors, Directorate Managers and Executive Lead for Directly Managed Units** will ensure:

- effective and practical local arrangements for the implementation of this policy;

- appropriate cross-Directorate /Locality/Specialties co-ordination and liaison to achieve compliance with this policy, particularly in relation to learning and sharing lessons and linkages between concerns, claims and incidents, with any further responsibilities more fully set out in the Claims Management Procedure.

5.7 **Unit Clinical Directors/Unit Medical Directors/Unit Nurse Directors** are responsible for ensuring effective and practical working arrangements are in place within the Locality/Directly Managed Unit to ensure implementation of and compliance with this policy and that these are fully communicated to staff, with their specific responsibilities more fully set out in the Claims Management Procedure.

5.8 The **Medical Director**, **Director of Nursing and Patient Experience and Director of Therapies and Health Sciences** are responsible for quality & safety issues and ensuring that medical, nursing and professions allied to healthcare professional issues identified through clinical negligence claims, are appropriately examined and addressed. Furthermore each Executive Lead will be responsible for authorising a breach of duty to be admitted in relation to breaches in the standard of care relating to their respective profession.

5.9 The **Director of Strategy** has Executive responsibility for Health & Safety and will ensure issues arising out of personal injury claims are appropriately examined and addressed.

5.10 The **Director of Finance** is responsible for maintaining the Losses and Special Payments Register (LaSPAR).

5.11 The **Assistant Director of Strategy** is responsible for authorising breaches of duty for personal injury claims.

5.12 The Health Board will employ competent **Legal Services Managers/Officers** who hold, or who are working towards, relevant qualifications at Degree Level and/or above, in Claims Handling and Risk Management, and who can demonstrate sufficient experience, specialised knowledge and expertise in the management of Clinical Negligence and Personal Injury claims.

5.13 The Legal Services Managers/Officers will be required to demonstrate on-going updating and continuing professional development in the area of claims management.

5.14 The Health Board will ensure that the Legal Services Managers/ Officers are given sufficient profile and seniority within the Health Board to achieve the objectives of WHC(97)17 and of the Putting Things Right Guidance (2013) Part 8. The Health Board will support the Legal Services Managers/Officers in the furtherance of their objectives.

5.15 The Legal Services Managers/Officers can demonstrate direct access to the Chief Executive and/or Executive Team, as necessary to achieve the objectives of WHC(97)17 and the Putting Things Right Guidance (2013) Section 8 for effective claims management.

5.16 The Health Board authorises the development of an appropriate escalation procedure to which it will give its full support to highlight the profile of the claims management process and its support for the Legal Services Team. The escalation procedure is designed to ensure that all members of staff throughout the Health Board acknowledge the importance of the Claims Management process and Board support thereof and will provide all necessary support to the furtherance of the objectives set out in this policy to ensure that claims are managed proactively, equitably and in an efficient and timely manner.

5.17 The Legal Services Managers/Officers will ensure that all members of staff and/or their line managers involved in a claim are kept informed of the progress and outcome of the claim.

5.18 **All staff** are encouraged to report adverse incidents, including those that may lead to claims for compensation, in line with the Health Board's promotion of an open and honest, blame free culture. Staff also have a duty towards the Health Board in the investigation and, where appropriate, defence of all claims and will assist all claims staff, as necessary during the claims management process to include the provision of written and oral testimony as appropriate.

5.19 The **Assurance and Learning Group ("A&LG")** reports to the **Quality & Safety Committee.** Its remit in relation to claims includes examination of serious cases, review of investigation outcomes, the examination of aggregated claims and trends, commissioning and approval of risk reduction/service improvement action plans and the monitoring of completion and effectiveness of those action plans.

5.20 The **Audit Committee** provides an assurance to the Board on financial management systems within the Health Board, which includes the financial management of claims and receives regular reports from the Director of Finance on the losses and special payments.

5.21 Approval of this strategic Claims Management Policy will rest with the Board although approval of the Claims Management Procedure and subsequent review and revisions of this Policy will be delegated by the Board to the Assurance and Learning Group.

6. DELEGATED LIMITS

Delegation of Out of Court Settlement

6.1 The Health Board acknowledges that the Welsh Government has delegated its responsibility for the settlement of claims to a limit of £1 million to the Health Board and that the Health Board continues to exercise this discretion subject to satisfaction with minimum requirements and standards:

- That it adopts a clear policy for the handling of claims which satisfies the requirements of WHC(97)17 and the Putting Things Right Guidance (2013) Part 8.
- That the requirements of WHC(97)17 and the Putting Things Right Guidance (2013) Part 8 form the basis of the procedure for the day to day management of claims.
- That an Appendix S is completed for every settlement authorised by the Health Board over £25,000 but within the delegated limit and that the Health Board can demonstrate that remedial action has been taken.

Internal Delegated Limits

6.2 The Health Board has formal delegated responsibility from the Welsh Government for the management of clinical negligence and personal injury claims valued up to £1,000,000.

6.3 The levels of delegated authority within the Health Board are those contained within the Scheme of Delegation of the Health Board's Standing Financial Instructions.

Payment Level @	Deputy Legal Services Manager	Legal Services Manager	Deputy Head of Risk & Legal Services	Head of Patient Experience Risk & Legal Services	Executive Directors	Chief Executive/ Deputy Chairman	Board
Up to £5K	✓	✓	✓	✓	✓	✓	✓
Up to £25K		✓	✓		✓	✓	✓
Up to £50K			✓	✓	✓	✓	✓
Up to £75K				✓	✓	✓	✓
Up to £250K					✓	✓	✓
Up to £500K						✓	✓
Up to £1m							✓

6.4 In situations where a decision is necessary and it is not possible to comply with the Scheme of Delegation limits because of time constraints, the Chief Executive, or nominated Executive Director, will contact the Health Board's Chairperson, or nominated Non-Officer Member and recommend a course of action (Chairperson's Action). Any action taken under Chairperson's Action will be reported to the next available meeting of the Board, seeking retrospective approval.

7. USE OF LEGAL ADVISORS

7.1 The Health Board will use legal advisors in the defence or settlement of significant clinical negligence and personal injury claims. Small to moderate value claims of moderate complexity, particularly where the injured person does not have the benefit of legal representation, may be managed in-house by the Health Board's Claims Manager under the Redress Regulations. The Health Board's contracts on a commercial basis for the management of personal injury claims. This contract will be reviewed from time to time to ensure continuing quality and value for money. Clinical negligence claims will be managed by Legal and Risk Services.

7.2 Where external legal advice is sought, the Health Board will retain the responsibility to direct its solicitors in respect of liability admission, defence, settlement and general tactics. The Health Board, however, will always take due account of qualified legal advice in making such decisions. Legal advice will cover:

- Liability and causation;
- An assessment of the strength of the available defence and probability of success;
- The likely valuation of quantum of damages including best and worst case scenarios; and
- Estimates of legal costs for claimant and defence.

7.3 For claims managed in-house, advice will be provided by the Health Board's Legal Services Team. In all such cases, advice will be recorded on the case file, satisfying the same requirements for the provision of legal advice as set out in paragraph 7.2 above.

7.4 The decision to settle a claim or to continue with its defence will be on the basis of legal advice of Counsel and/or Legal and Risk Services, in conjunction with the Legal Services Team and Locality/Directly Managed Unit Directors. In the event of consideration being given to run a claim to trial, the Executive Team will be notified via the Chief Executive High Risk Meeting.

8. REPORTING REQUIREMENTS

8.1 The Health Board delegates its responsibilities to the Quality & Safety Committee and Audit Committee as the duly authorised committees. The Committees will receive and review quarterly progress reports on the

management and status of claims against the Health Board, in the format specified by WHC (97)17 and the Putting Things Right Guidance (2013) Part 8. The claims report will include information on:

- The Health Board's claims profile and claims management record
- Key issues and/or major developments affecting the Health Board
- Number of claims
- Aggregate value of claims in progress
- Details of any major claims
- Progress and likely outcome of significant ongoing claims including expected settlement dates
- Value of claims settled and final outcomes
- Relevant trends
- Information regarding remedial action as appropriate.

8.2 The Quality and Safety Committee will receive and approve the Annual Patient Experience Claims and Concerns Report reporting on comparative issues at the end of the relevant financial year. It will also receive reports from the Assurance & Learning Group that demonstrate the linkages between incidents, concerns and claims.

8.3 It is acknowledged that where a claim has been identified as a Patient Safety Incident, although has not been reported as an issue, the handler will ensure that the Locality/Directly Managed Unit complete a retrospective incident form on Datix. The National Patient Safety Agency for the National Reporting and Learning System will be sent the incident report retrospectively as appropriate following a review.

8.4 The reporting requirements relating to the reimbursement process managed by the Welsh Risk Pool are set out in Paragraph 16 as follows.

8.5 The reporting requirements to the Welsh Government are set out in Paragraph 12 as follows.

9. CLAIMS MANAGEMENT PROCEDURE

9.1 The Health Board will ensure that a Claims Management Procedure is developed which supports and embraces the objectives contained in this Policy and WHC(97)17 and the Putting Things Right Guidance (2013) Part 8.

9.2 The Claims Management Procedure will set out the processes and procedures for the day to day practical management of claims and associated matters.

9.3 The Board delegates the authority for the approval of the Claims Management Procedure to the Assurance & Learning Group.

10. INVOLVEMENT OF FRONT LINE STAFF

10.1 The Health Board recognises that the co-operation of all staff involved in the incident leading to a claim is crucial to the early collation of information to that case. The Health Board will ensure that such staff are encouraged to support the Legal Services Team and any duly appointed legal advisors, in the handling of that claim. All staff are required to fully and openly co-operate with the investigation of any legal claims and to comply with this Policy and the Claims Management Procedure.

10.2 Once an incident has been reported, the Legal Services Team or the Health Board's legal advisors will establish an objective account of the original incident at the earliest available opportunity, taking advice from colleagues where appropriate.

10.3 Unless there are exceptional circumstances, any member of staff asked to do so should provide the Legal Services Team or Legal Advisor with written comments and information regarding the investigation of the relevant claim in a timely manner. The Health Board will support an escalation procedure to be contained in the Health Board's Claims Management Procedure to secure this objective.

10.4 The Health Board recognises that providing a statement and giving evidence can be a stressful experience and will ensure that full support and guidance is provided to members of staff who are asked to give evidence on behalf of the Health Board.

10.5 The Legal Services Team will ensure that the Locality/Directly Managed Unit is informed of the outcome of all claims affecting their service area and that all relevant managers and witnesses are kept informed of pertinent developments throughout the course of a claim.

10.6 The Health Board will take full responsibility for managing and, where appropriate, settling claims in clinical negligence and personal injury cases meeting all its financial obligations and will not seek to recover any costs from health professionals. In very exceptional cases, where the health professional was legally found to be acting outside of his/her remit the matter will be referred to the appropriate Executive Director.

11. NUISANCE CLAIMS

11.1 The Health Board will not settle claims of doubtful merit, however small, purely on a 'nuisance' value basis. Similarly claims will not be inappropriately defended.

11.2 The decision to settle a claim will always be based upon an assessment of the Health Board's legal liability and the risks and costs associated with the defence of that claim, including the prospects of recovering those costs in the event that the defence is successful.

12. REPORTING OF CLAIMS TO WELSH GOVERNMENT

12.1 Novel, Contentious or Repercussive Claims

The Legal Services Team will monitor the nature and type of claims received to highlight any claims which are considered to be novel, contentious or repercussive. In such cases the Legal Services Managers/Officers will liaise with the designated Solicitors/Legal Advisors, to ensure that the Welsh Government are duly made aware or advised. The Head of Patient Experience, Risk and Legal Services or his/her deputy will be kept informed throughout.

12.2 Claims Exceeding the Delegated Authority

Any claims with damages estimated to exceed the Health Board's delegated authority of £1 million are to be reported to Welsh Government and prior approval is obtained in advance of liability being conceded and the claim being settled, either by the Health Board's legal advisors or by the Legal Services Managers as appropriate.

13. DATABASES

13.1 The Health Board will maintain two databases:

13.2 Datix

The Health Board's claims data-base will contain the information prescribed in the Claims Management Procedure.

13.3 LaSPaR

The Losses and Special Payments Register (LaSPaR) is a computerised database introduced by the National Assembly for Wales for actioning write-offs or special payments approval. The main objectives of LaSPaR are to:

- Ensure that health bodies monitor all aspects of losses and special payments, from initial registration to final outcome, on a case by case basis;
- Allow health bodies and the National Assembly to identify settlement/ claimant costs, provisions, and defence or other administration costs provisions, and to action any subsequent adjustments; and
- Ensure that all payments and income recoveries are identified separately and that analyses can be performed on all transactions.

13.4 All clinical negligence and personal injury claims will be entered onto both databases. Other losses and special payment details will be similarly recorded.

13.5 The Health Board will ensure that patient and staff confidentiality is maintained.

14. LINKS BETWEEN CLAIMS, CONCERNS, INCIDENTS AND OTHER RISK INFORMATION

14.1 The Health Board recognises the need for close connections between risk management, concerns, incidents and the management of claims. It appreciates the need for close and co-operative working between these functions and will ensure that appropriate linkages are in place to facilitate this objective.

Linkages

14.2 The primary means of ensuring practical linkages between incidents, concerns and claims will be via interrogating the Health Board's Datix modules. Such information will be available to the Legal Services Managers/Officers, to include:

- Details of the potential claimant
- Date and details of incident/outcome from which the claim might arise
- Names and contact details of relevant members of staff involved in or witnessing the incident
- Statements by such relevant members of staff and witnesses
- Relevant documentation.

14.3 The Learning and Assurance Group will be the appropriate forum for the lead members of staff for concerns, incidents, risk and claims to meet on a regular basis to ensure the identification of any trends and remedial action that may be required. Appropriate and relevant staff will then implement any recommendations arising from this forum.

14.4 The DATIX system identifies where a potential claim has previously been reported as an incident or concern. This facilitates the gathering of information to comply with the relevant Pre-Action Protocols.

14.5 The Health Board will endeavour to produce appropriate reports combining information on concerns, claims, risk and incidents to relevant groups to enable information to be cascaded through all levels of the organisation.

15. LEARNING LESSONS FROM CLAIMS AND PREVENTING CLAIMS FROM INCIDENTS AND CONCERNS

15.1 The Health Board is committed to learning lessons from claims, concerns and adverse incidents, ensuring that remedial actions are implemented and monitored following every claim where admissions of liability have been made or where failings were identified during the course of investigation.

15.2 The Claims Manager will identify the potential for 'learning lessons' from all claims. The Health Board will ensure that a formal process and procedure to support the learning of lessons, monitoring of implementation of lessons learned, evaluation of the efficacy of lessons learned and thereafter the auditing of each component, is developed and is set out in its Claims Management Procedure or associated document.

15.3 In accordance with the Health Board Risk Management Strategy, lessons are also learned from wider experiences, including the experiences of other Health Boards, feedback from the Welsh Risk Pool, feedback from the National Patient Safety Agency, legal developments/case law, other agencies/bodies and benchmarking. These will also generate improvement strategies aimed at learning lessons, changing practice and reducing future risk.

15.4 The Concerns Investigators will identify the potential for the use of alternative dispute resolution before considering litigation. In addition, the Health Board is committed to ensuring the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 is used to ensure that patients receive, where appropriate, an apology and a full explanation of what went wrong to reduce the potential for complainants to take legal action to achieve such a remedy.

15.5 The Legal Services Managers/Officers will produce an Appendix S and put arrangements in place for an associated Action Plan for all claims exceeding the Health Board's excess of £25,000. This will be used as the basis for learning, monitoring and evaluating the efficacy of the lessons learned from claims together with the necessary data entry into Datix.

16. LIAISON WITH THE WELSH RISK POOL

16.1 The Welsh Risk Pool is the risk pooling scheme run for the benefit of members of NHS Wales and it is funded through the Welsh Government by a top slicing arrangement.

16.2 The Health Board is assessed annually against the Welsh Risk Pool Standard for Claims Management.

16.3 The Health Board will comply with the various rules and procedures of the Welsh Risk Pool. The Claims Manager will ensure the Health Board's adherence to the same.

16.4 The Health Board will notify the Welsh Risk Pool of any claims which are handled by either external or in-house solicitors i.e., those other than L&RS, which are likely to exceed £25,000 by lodging a WRP2 form with the Welsh Risk Pool.

16.5 In order to be reimbursed by the Welsh Risk Pool, the Health Board is required to submit, electronically via NWSSP WRPS Claims & Reimbursement e-mail, Appendix U, Costs Schedule, Appendix S and Action Plan in accordance with the Welsh Risk Pool Services Claims Reimbursement Procedure.

16.6 The Health Board acknowledges that the Welsh Risk Pool will periodically undertake reviews of claims managed by the Health Board. The Health Board will ensure the co-operation of its members of staff with such reviews through the development of a formal claims review procedure to be contained in the Claims Management Procedure.

17. NHS REDRESS REGULATIONS 2011

17.1 The Health Board appreciates and is committed to the objectives of the NHS Redress Regulations 2011 which has developed a small value clinical negligence scheme for Wales.

17.2 The Health Board will undertake such action as it deems appropriate to support the Redress Scheme in accordance with the Regulations and which will be included in its Claims Management Procedure.

18 CONFIDENTIALITY

18.1 Information gathered during the course of a claim will be stored in a suitably secure manner. Such information will be shared with the Health Board's legal advisors as necessary. Where such information is not privileged, it may also be released to litigants or their representatives in the interests of protecting the Health Board's legal position or in accordance with the Health Board's legal obligations of disclosure.

18.2 Information obtained during the course of a claim will be stored within the Datix system and/or hard copy file. This will include elements of personal information relating to staff and patients. In the interests of good governance and risk management, such information may be used for analysis; including analysis linked to the practice and behaviour of individuals. Such analysis will be shared on a 'need to know' basis only. All such analyses are confidential and must be handled and stored accordingly by all concerned.

18.3 From time to time the Medical Director will be required to provide information pertaining to the Health Board's claims profile. When such information is to be available for public inspection, the data will be presented in such a way so as to comply with Caldicott guidelines.

APPENDIX 1

References

Civil Procedure Rules 1998
WHC(97) 7 – Clinical Negligence and Personal Injury Litigation: Structured Settlements.
WHC(97) 17 – Clinical Negligence and Personal Injury Litigation: Claims Handling.
WHC(98) 8 – NHS Indemnity – Arrangements for Handling Clinical Negligence Claims against NHS Staff.
WHC(99)128 – Handling Clinical Negligence Claims: Pre Action Protocol.
Limitation Action 1980.
NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011
Putting Things Right Guidance on Dealing with Concerns about the NHS Version 3 November 2013.
The Welsh Risk Pool Services Claims Reimbursement Procedure.
The Welsh Risk Pool Claims Management Standard (April 2007).
Delegated Authorities – Standing Financial Instructions.

LEGAL SERVICES DEPARTMENT

CLAIMS PROCEDURE

Approved by	Date	Review Date
	November 2017	November 2020

CONTENT

ABM UNIVERSITY LOCAL HEALTH BOARD ('THE LHB')
PROCEDURE FOR THE DAY TO DAY MANAGEMENT OF CLAIMS

1.0 Background

1.1 This procedure which is designed to set out the procedure for the day to day management of claims received by The LHB supports the strategic objectives set out in the LHB Claims Management Policy. It has also been drawn up in accordance with Welsh Health Circular (97)17 "Clinical Negligence and Personal Injury Litigation: Claims Handling", WHC (99)128 "Handling Clinical Negligence Claims: Pre Action Protocol for the Resolution of Clinical Disputes" and other guidance, as well as Welsh Risk Management Claims Management Standard (April 2007).

1.2 The investigation management and conduct of all claims and the conduct and control of all claims documentation is the responsibility of the relevant Head of Risk Management & Legal Services.

2.0 Potential Claims

2.1 Every concern has the potential to become a claim and the quality of investigations undertaken by the Local Health Board under its Risk Management Policy and Strategy and Putting things Right Policy, should place it in a good position to manage future litigation.

2.2 All concerns (incidents, complaints and claims) are recorded on the LHB's Datix database and linked as appropriate to facilitate the identification of potential claims and ensure a single seamless investigation.

3.0 New Claims

3.1 A new claim record will be opened within 3 working days of receipt of one of the following:

- A request for Health Records, which indicates an action for Clinical Negligence as being contemplated against the Local Health Board.
- A letter providing details of allegations of clinical negligence or personal injury that can also be described as a 'Letter of Claim'
- A request for compensation to be paid arising out of an incident involving NHS staff or services.

4.0 Action Upon Receipt of a New Claim

4.1 Upon receipt of a new claim the Legal Services Department in the LHB will:-

- Set up a record of the claim on the Claims module of the Datix database
- Ensure that there is an appropriate link to any concerns or incidents record, and locate copies of any relevant pre-litigation papers.
- Acknowledge the letter to solicitors

- Instruct relevant solicitors to act on behalf of the LHB
- Notify the relevant Unit Medical Director, Unit Nurse Director, Unit Service Director and the relevant Governance Team.
- Notify the Head of Risk Management & Legal Services, Executive Medical Director and Director of Nursing & Patient Experience or their representatives via weekly reports and bi-monthly listings prepared for the Assurance & Learning Group within Directorate/Locality/Directly Managed Units reports.
- Notify any other appropriate personnel which may include relevant professional leads
- Contact Subject Access for the release of Clinical Records, the relevant Department for Personal Records and Occupational Health for Occupational Health Records, as appropriate
- Information on any claims received involving occupation stress, bullying or harassment will also be referred to the Director of Workforce and OD
- Enter the case on The Losses and Special Payments Register (LaSPaR)

5.0 Instructing Solicitors

5.1 The LHB currently engages the services of Legal & Risk Services (L&RS) for the Case Management of Clinical Negligence and Personal Injury Claims as appropriate and necessary and they will be instructed on the receipt of a request for Health Records, which indicates an action for Clinical Negligence as being contemplated against the Local Health Board or correspondence defined as a 'letter of claim' under the Personal Injury Pre-Action Protocol.

5.2 L&RS may be instructed on receipt of any other request for compensation arising out of an incident involving Health Board staff or services, depending on the value and complexity of the case and may or may not be asked to assume conduct of communications with the Claimant if they are a litigant-in-person or their representatives.

5.3 In respect of Clinical Negligence, L&RS do not invoice for this service, because of the manner in which they are funded by the NHS in Wales. L&RS will, however, request payment of disbursements as and when they are incurred during the course of the claim. These will be processed within the Legal Services Department in accordance with internal processes and delegated financial limits set out in the Standing Financial Orders.

5.4 In respect of Clinical Negligence claims, L&RS have delegated authority on a number of issues, related to the day to day management of claims. These are fully set out in Appendix 1 and may change from time to time, as agreed with the Managing Solicitor at L&RS. They include, but are not limited to:

- The choice/identity of expert witnesses
- The choice /identity of barristers/counsel
- The choice/identity costs draftsmen
- Acquisition of copy records from other parties when necessary.

5.5 At the conclusion of any Personal Injury Cases in respect of which L&RS has acted, they will submit an invoice for services carried out in respect of that claim payable to Velindre NHS Trust. The invoices will be delivered to the Legal Services

Department and discharged in accordance with the Department's internal processes and provisions of the Health Board's Standing Financial Orders.

6.0 Pre-Action Protocols

6.1 It is the policy of the LHB wherever possible to complete its investigation and to make a formal determination on issues relating to liability into personal injury and clinical negligence claims within the Pre Action Protocol Period.

6.2 The LHB acknowledges that adherence to the Pre Action Protocol promotes better investigation, and better and earlier exchange of information. It also acknowledges, that adherence to the timescales set out in the protocol should ensure that the LHB is in a better position to settle claims earlier without the need for legal proceedings. Where court proceedings are subsequently issued, a thorough and timely investigation undertaken under the Pre Action Protocol will enable such subsequent proceedings to run efficiently and to timetable.

6.3 All claims are managed in accordance with the relevant Protocols for Clinical Negligence and Personal Injury Claims pursuant to the Civil Procedure Rules.

6.4 The aim of the Protocol is to encourage settlement of claims without the need for legal proceedings. Settlement is encouraged by promoting openness between parties and co-operation in the process of obtaining the evidence necessary to determine liability and value the claim.

6.5 The overriding objective of civil litigation is to enable the Courts to deal with cases justly. Claims are governed by a set of Court Rules which are designed to ensure that dealing with a case justly will include so far as practicable the following:-

6.5.1 Ensuring that all parties are on an equal footing
6.5.2 Saving expense
6.5.3 Dealing with the case in ways which are proportionate to the money involved, the importance of the case, the complexity of the issues and the financial position of each party
6.5.4 Ensuring that it is dealt with expeditiously and fairly
6.5.5 Allotting it to an appropriate share of the Court's resources.

6.6 All claims should be initiated by either a letter from the Claimant or their representative and for personal injury claims via the Personal Injury Claims Portal indicating the potential contemplation of a claim against the LHB or a Letter of Claim sent by the Claimant or their representative to the LHB. This letter should include sufficient information to enable the LHB to determine when, where and how the Claimant's accident occurred together with a summary of the injuries sustained by the Claimant.

6.7 In order to successfully claim compensation, the Claimant must prove that the accident and injuries were caused by the negligence and/or breach of statutory duty of the LHB. The Claimant has to show that somebody was legally at fault and these reasons are set out in the Letter of Claim usually as "allegations of negligence and/or breaches of statutory duty".

6.8. The Letter of Claim should also give an indication of any financial loss or expense incurred and continuing as a result of the accident.

6.9 Once a Letter of Claim has been received, the LHB is required to acknowledge this within 21 days of its receipt failing which the Claimant is entitled to commence legal proceedings.

6.10 Once the LHB has acknowledged the Letter of Claim, it has a maximum of 3 months to investigate the claim in Personal Injury cases, or 4 months in respect of Clinical Negligence claims and to respond to the Claimant's Solicitors. In this response the LHB must state whether or not it admits that it is liable for the injury and harm sustained.

6.11 If it is not accepted that the LHB was at fault, then we must provide the Claimant with a detailed explanation for this denial. In addition where there is a denial of fault, then it is necessary to enclose with the Letter of Response all the documents which are relevant to the issues in dispute which support the case but also any which may in fact hinder the case.

6.12 In some cases the LHB accepts some of the blame but also feels that the Claimant is partially to blame for the incident and the injuries suffered. In such circumstances, the LHB will have to give a full explanation as to why it considers the Claimant to be partly to blame and again where there are any documents relevant to this these must be provided. Alternatively, it may accept that there was a failure in the standard of care provided, but denies that this resulted in any or any additional harm to the patient. In other words, breach of duty is admitted but causation is denied. Again, the Health Board must set out the basis for its clinical opinion which may be derived from internal or external review of the case.

6.13 Where liability is accepted, the parties can then turn their attention to valuing the claim. This includes obtaining the Claimant's Schedule of Special Damages which prove any losses or expenses which has been incurred as a consequence of the injury. In addition, medical evidence will be obtained to explain exactly what injuries have been sustained by the Claimant, the treatment received and the extent to which the Claimant will or will not make a full recovery.

6.14 Where the LHB does not accept that it is at fault, then detailed reasons must be provided in support of the refusal and further all the documentation which the LHB relies upon in support of its denial must be served at the time the Letter of Response is sent.

6.15 This is to enable the Claimant's Solicitors to consider the LHB's response and documentation so that if they on the basis of the evidence provided believe that the Claimant's case will fail, then the claim will not be pursued. If on the other hand following the review of the reply provided, they still feel that the case will be successful, then Court proceedings can be commenced.

6.16 The intention was that the steps set out above would become the normal and reasonable response to Personal Injury and Clinical Negligence claims. Where Solicitors' do not follow the protocol, if proceedings are subsequently issued the Court will take into account the fact that the protocol has not been followed which can have adverse consequences in relation to their ability to recover legal costs on behalf of their client.

6.17 The specific implications for the LHB in relation to compliance with the Protocol include the following:-

- The LHB is required to disclose relevant documentation within 3 or 4 months of receiving the claim, as set out in the table below. Standard disclosure lists are set out in the protocol. The LHB is obliged to give disclosure of all relevant documentation failing which it is obliged to provide a detailed explanation as to why it cannot be provided.

- The Claimant may issue an application for pre-action disclosure of documentation. Such applications can routinely cost the LHB between £800 and £2,000 in wasted costs and further, if the order is breached and there is a failure to provide the documentation, the LHB can then not rely upon that documentation if it is subsequently found. Further costs can be awarded on an indemnity basis which is higher than usual.

- The LHB can be penalised in awards of costs and interest especially if non-compliance with the Protocol has led to the commencement of proceedings which might ordinarily have been avoided or costs incurred unnecessarily.

- The Court may order the LHB to pay money into Court if it has without good reason failed to comply with the Pre-action Protocol. The monies paid into Court will act as a security for any damages subsequently found to be payable within the proceedings including costs.

- Further in such cases the Court can order the party in default of the Protocol to pay the other parties costs on an indemnity basis. This means a full recovery of all legal and other costs at a higher level than usually payable.

6.18 Compliance with the Protocol cannot be understated. This costs the LHB money in wasted costs, but evidentially where documents have not been disclosed this can prevent the LHB from effectively defending claims.

6.19 The LHB will use the Pre-Action Protocol Period to ensure that every effort is made to discuss and negotiate resolution and settlement of claims prior to Court proceedings, following a thorough investigation and determination of the liability issues on the basis of expert advice received. Where necessary, the LHB will enter in face to face or mediation type meeting with the Claimant and/or the Claimant's solicitors to facilitate such negotiated resolution.

7.0 Procedure for Handling Claims

7.1 The Legal Services Department will ensure that the following steps are undertaken as necessary when managing a claim:-

- Ensure that key administrative actions are undertaken, in accordance with the Departmental process document for opening new claims as indicated in 4.0 above.
- Establish an account of the original incident.
- Identify and maintain all records relating to the incident.

- Obtain statements from front-line staff involved in the incident giving rise to the claim in conjunction with the Health Board's solicitors as appropriate.
- Gather and collate all relevant information and/ or evidence for forwarding to solicitors instructed.
- Obtain in-house or external 'expert' view in conjunction with the LHB's solicitors as appropriate.
- Deal with telephone, email and letter queries from solicitors, experts, and others.
- Develop case action plan as appropriate.
- Maintain an appropriate claims review system.
- After having established a relationship with all staff involved in the claim, to maintain that relationship and communicate on a regular basis to discuss and pre-empt any concerns with staff.
- Identify any resources required e.g. support required for the collation of evidence.
- Ensuring relevant types of support are available and advised upon e.g. Line Manager, peer support from colleagues across the LHB who have been involved in a similar experience.
- Provide support to witnesses who are likely to be called to Court (provided either individually or on a group depending upon the circumstances and appropriateness).
- Arrange regular meetings as required with staff, experts, Counsel and Legal Advisors who will advise where appropriate.
- Ensure that requests for payment are authorised and passed to the Accounts Department for processing in a timely manner.
- Instruct solicitors when appropriate and monitor their involvement and costs.
- Negotiate out-of-court settlements as appropriate.
- Consider all options relating to the use of Alternative Disputes Resolution and/or Mediation as appropriate in each case.
- Liaise with the Welsh Risk Pool and all relevant third parties.
- Following the decision to resolve the claim, commission an action plan from the relevant service area, ensuring its presentation at the Directorate /Locality /Directly Managed Unit appropriate Group/Board.
- If appropriate and in consultation with the Head of Risk Management & Legal Services, include any relevant risks identified on the Local Health Boards Risk Register/s
- To complete all relevant documentation and submit to Welsh Risk Pool on settlement of the claim and in accordance with the timescale set.

8.0 Litigants in Person

8.1 The LHB acknowledges that claims management systems should embrace and allow for more pre action contact with Claimants.

8.2 To facilitate this and also to support the spirit and intention of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and Putting things Right guidance on dealing with concerns about the NHS from 1st April 2011, where a Claimant does not have Solicitors acting and is acting effectively as a litigant in person, requests for compensation will be managed and investigated in accordance with the spirit of the Regulations.

8.4 Every effort will be made during the informal claims settlement process to liaise with the Claimant and enter into dialogue with them including face to face discussions where appropriate regarding the claim.

8.5 The procedure also provides for the early evaluation of the claim by appropriate experts be they internal or external clinical experts or legal experts.

8.6 The objective of the informal claims settlement process, is to facilitate wherever possible the internal and/or pro active resolution of claims which minimises expenditure on legal costs and stress to staff involved. The LHB will therefore consider Alternative Disputes Resolution methods including Mediation in appropriate cases to facilitate negotiated resolution of cases.

9.0 Disclosure

9.1 *Internal Disclosure:* on receipt of a claim for Clinical Negligence or Personal Injury, a request will be made for records in the interests of gathering relevant documentation complying with the obligation of disclosure under any pre action disclosure that may have been triggered.

9.2 *Disclosure to Third Parties*: the LHB will ensure that appropriately documented claims for disclosure of health records and other appropriate records will be made in accordance with the requirements contained under the Data Protection Act 1998 and the Access to Health Records Act 1990. The LHB will ensure wherever possible adherence to the 40 day time limit for the disclosure of records acknowledging, that the better and earlier exchange of information acknowledging the benefits and the better and earlier exchange information and provision of documentation.

9.3 *Authority to Disclose:* the LHB will ensure the relevant authority is obtained prior to disclosure.

10.0 Deadlines for Responding to Claims

10.1 The tables summarises the key obligations of the LHB under the pre-action protocols for Clinical Negligence or Personal Injury Claims. Failure to comply with protocols has a serious adverse effect and can result in direct financial penalties for the LHB.

Clinical Negligence Protocol	Personal Injury Protocol
• Provide a letter of acknowledgement within 21 days of receipt of a Letter of Claim.	• Provide a letter of acknowledgement within 21 days of receipt of a Letter of claim.
• Provide confirmation that a claim is admitted within 4 months of receipt of the Letter of Claim	• Provide confirmation that a claim is admitted within 3 months of receipt of the Letter of Claim.
• Provide a detailed Letter of Response within 4 months of receipt of the Letter of Claim if following	• Provide a detailed Letter of Response within 3 months of receipt of the Letter of Claim if following investigation of the claim is to be denied

Clinical Negligence Protocol	Personal Injury Protocol
investigation the claim is to be denied • Any documents that the LHB relies upon to support that denial are to accompany the Letter of Response. The Medical Records will ordinarily have been already disclosed, however, the LHB must ensure that concerns documents and documents gathered during investigations that were not instigated in contemplation of proceedings have been disclosed • Where any documentation has become lost the Legal Services Department will ask the Department Head lead to provide a witness statement setting out the searches that have been undertaken or alternatively obtain such a statement from another responsible person.	• Any documents that the LHB relies upon to support that denial are to accompany the Letter of Response. • Where any documentation has become lost the Legal Services Department will ask the Department Head lead to provide a witness statement setting out the searches that have been undertaken or alternatively obtain such a statement from another responsible person.

10.2 The LHB acknowledges the importance of the time limits set out in the Personal Injury Pre Action Protocol referred to above and acknowledges the better and earlier exchange of information places the LHB in a better position to settle appropriate claims earlier without the need for Court proceedings. Alternatively where the LHB has a defence to proceedings the better and earlier investigation places the LHB in a stronger position to manage the subsequent proceedings served appropriately and in accordance with the Courts time table.

10.3 Where Court proceedings are subsequently issued, the Legal Services Department will ensure that the Court proceedings are managed efficiently and wherever possible, ensure adherence to the time scale for directions set by the Court.

11.0 Making Decisions on Liability

11.1 A decision on liability can be made at any time during the course of a claim dependent upon the outcome of the investigations undertaken and the Legal Services Department will make every effort where possible to negotiate settlement of cases prior to the issue of Legal Proceedings.

- *Denial*: where the Legal Services Department recommends maintaining a denial of liability in respect of a claim, the relevant Unit Medical Director, Unit Nurse Director, Unit Service Director, relevant professionals involved and relevant Governance Team will be informed.

- *Admissions where the advice is to make an admission of liability*: Consultation will take place with all relevant personnel involved in the case to ensure that they have an opportunity to comment on the proposed course of action and admissions will be authorised in accordance with the delegated limits set out in the Standing Financial Orders. For Clinical Negligence claims authority should be obtained for making an admission of liability from the Executive Medical Director or Nominated Deputy. For Personal Injury claims authority should be obtained for making admissions of liability from the Director of Strategy or Nominated Deputy.

- *Alternative dispute resolution*: at any stage of the claim, consideration can be given to whether any appropriate method of alternative dispute resolution can be employed to resolve the claim.

- *Referral to the Welsh Government*: in cases where referral is required, this will be undertaken by L&RS on behalf of the LHB although the conduct of the claim will remain with the LHB, notification will be made in respect of the following cases

    - Where the damages on a claim exceed or are anticipated to exceed £1 million.
    - Where any claims involve novel, contentious or repercussive payments or issues or include potential class actions or in actions where an adverse incident would set an unfortunate president for the NHS as a whole.

12.0 Court Proceedings

12.1 Where proceedings are issued and served on the LHB, the Legal Services Department will ensure that the Acknowledgment of Service Form has been filed at the Court by L&RS within the fourteen days of being served with the proceedings. Following service of the Claim Form, the LHB has a strict deadline of 28 days in which to provide its defence or to obtain an extension of time thereto.

12.2 The Legal Services Department will ensure that Court proceedings are run efficiently and to time table throughout the duration of the claim.

12.3 Where a claim is also the subject matter of a concern under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, the LHB may continue with the concerns investigation until such time as court proceedings are formally served upon the LHB. The Legal Services Department will ensure that a co-ordinated approach is taken to dealing with both processes.

13.0 Assessment of Quantum and Settlement

13.1 Assessment and settlement of damages may occur at the same time as an admission of liability, but more usually follow at a later date when further evidence in relation to medical condition and prognosis have been gathered and or schedules of special damages have been served on each party. Every effort should be made, particularly where the value of the claim is modest, to attempt to quantify damages at the time of making an admission so that an early offer can be made.

13.2 Quantum will be assessed using the Judicial Studies Board Guidelines and relevant case authorities obtained from Lawtel and in appropriate cases, the LHB may seek independent expert evidence from a variety of disciplines to assist in valuing the damages claim including Counsel.

13.3 Negotiation of Quantum with Litigants-in-person: In such cases, the litigant-in-person will be provided with a breakdown showing how the quantum has been calculated. This will include a special damages calculation based upon the information provided by the litigant-in-person and evidence to support the calculation of general damages including copy documentation in support which may include:-

- Judicial Studies Board Guidelines
- Lawtel
- Decided Case Authorities.

13.4 In the event that the offer is not acceptable to the litigant-in-person, options for arbitration should be considered such as the obtaining of Counsel's advice together with advice to the litigant-in-person as to sources of legal advice available to them.

14.0 Delegated Limits for the Settlement of Claims

14.1 The delegated limits for losses and special payments are set out within the LHB's Standing Financial Instructions and may change from time to time.

14.2 Amounts of £1 million or over require authorisation from Welsh Government.

15.0 Dealing with Claims for Damage to LHB Property

15.1 The Welsh Risk Pool provides cover in certain circumstances, more fully set out in WRP guidance and technical notes, to reimburse LHBs for the financial loss associated with damage to LHB buildings or property, other than motor vehicles. This is subject to the usual excess of £25,000.

15.2 The LHB needs to identify at an early stage all incidents involving damage to LHB property other than motor vehicles where there is a potential for a loss of greater than £25,000, in line with the time limits set out in the Incident Reporting Policy and Procedure. Those responsible for reviewing and approving incidents should make contact with the Legal Services Department on identification of such an incident, to discuss the investigation required and the process to be followed.

15.3 On being notified of a potential property damage claim, Legal Services Department staff will open a record in the claims module of Datix and liaise with the WRP as to any specific requirements they may have (in particular, the appointment of a Loss

Adjuster or legal advisers). Sufficient information should be provided by the Directorate/Locality/Directly Managed Unit lead in order to provide financial reserves to both the WRP via a WRP2 form and Finance Directorate.

15.4 Reports on the likely value of any property claim to the WRP should be reported in the normal way and in accordance with the delegated limits set out in the Standing Financial Orders.

16.0 Learning Lessons from Claims and Events

16.1 It is important that the LHB makes constructive use of information which arises from clinical negligence and personal injury claims and that any remedial action where appropriate is taken to prevent or minimise the risk of further occurrence.

16.2 In order to reduce the risk to the LHB, every claim will be closely reviewed, with the assistance of the any relevant professional leads, such as Unit Medical Directors, Unit Nurse Directors and Unit Service Directors as appropriate. The aim is to identify the failures in the systems, which lead to the claim.

16.3 Root cause analysis following a thorough investigation may be undertaken to reveal the latent factors, which led to the circumstances of the claim, ensuring that remedial action is identified and taken.

16.4 To initiate the process, the Legal Services Department will provide a claims review to the relevant directorate lead as and when failings are identified and/or claims are finalised.

16.5 The Assurance and Learning Group will oversee this process and in particular ensure that:

- Any failures in the systems which led to the claim have been identified
- Ensuring that remedial action is identified
- Ensuring the remedial action is taken
- Ensuring that there are appropriate auditing and monitoring processes in place and that links with appropriate Committees e.g., Clinical Audit are made

16.6 Thereafter, the information and action plans provided will be used to inform the completion of the Appendix S documentation on the settlement of the claim.

17.0 Using Risk Registers

17.1 Where risks identified from the learning lessons process cannot be eradicated or sufficiently minimised or outstanding requirements for remedial action remain, these will be added to the relevant risk register within the Directorate/Locality/ Directly Managed Unit by the person with such responsibility, as appropriate. Where risks of a corporate nature are identified, the Head of Risk Management & Legal Services will ensure that such risks are added to the Corporate Risk Register.

17.2 Risk registers are reviewed by the Assurance & Learning Group, which reports to the Quality & Safety Committee.

18.0 NPSA Reporting

18.1 Where a claim, with an incident date post-dating 1st January 2004, has been identified as a patient safety incident but was not previously reported through the incident reporting process, the Legal Services Department will notify the relevant Directorate/Locality/Directly Managed Unit to ensure that a retrospective incident is reported which will be subsequently exported to the National Reporting and Learning System (NRLS).

19.0 Claims for Reimbursement on the Welsh Risk Pool

19.1 Claims exceeding £25,000 can be the subject of a reclaim by an NHS body from the WRP.

- Where settlements are made which exceed the current threshold of £25,000, the LHB must seek reimbursement of the excess costs above the threshold. The usual process would be to apply to the Advisory Board of the WRP, by completion of an Appendix U Form, a Payment Schedule, an Appendix S form and relevant action plan**.** Reimbursement would then be made within ten days after Advisory Board's approval of payment of the claim.

- Where interim payments on an ongoing case exceed £100,000 the LHB can seek reimbursement using the process as stipulated above.

19.2 The Legal Services Department will ensure that the LHB complies with the requirements of the current WRP Reimbursement Procedure.

20.0 Audit

20.1 In order to comply with the requirement of the WRP Claims Management Standard, the LHB's Internal Audit Service will, each year, undertake an audit of 25% or 25 of all claims (whichever is the fewer number) which should originally be subjected to the WRP Reimbursement Process.

20.2 This will ascertain the accuracy of reports, costs, compensation claims and, further to ascertain that claims/refunds are dealt with in accordance with the Welsh Risk Pool Reimbursement Scheme.

20.3 In addition, the Health Board's Internal Audit Department may conduct audits against other aspects of claims management processes from time to time.

21.0 Indemnity

21.1 The LHB has vicarious liability for all its employees when they are providing core activity services during the course of their employment.

21.2 Welsh Office Circular (98)8 sets out the LHB's responsibilities in connection with the indemnification of staff for clinical negligence claims. The main points are as follows: -

- The LHB will not seek to recover any proportion of costs from Healthcare professionals or others covered by NHS Indemnity or from any other private indemnity policies they may have.
- The NHS bodies will not be responsible for a Healthcare Professional's private practice even if this is performed in a NHS Hospital. It is therefore advisable that Professionals who might be involved in work outside his/her LHB employment should have professional liability cover.

- Where any Health Professionals are involved in the care of private patients in the NHS setting they would normally be doing so as part of their NHS contract and would therefore be covered by the NHS.

22.0 Support for Staff Involved in Claims

22.1 The LHB will ensure, that members of staff who are involved in claims will be supported through the entire process.

22.2 Initially the individual's Line Manager will provide support but the Legal Services Department will provide such support and assistance to members of staff involved in litigation as appropriate and as matters progress.

22.3 This will be determined on an individual basis dependent upon the requirements of each individual and can include staff meeting with the Legal Services Department to discuss the claims process and/or L&RS Solicitor.

23.0 Reporting Procedures

Internal Reporting Procedures

23.1 The Assurance & Learning Group is a sub-group of the Quality & Safety Forum. Its remit is to share the learning from incidents, complaints and claims across the Health Board.

23.2 The Quality & Safety Forum oversees all Executive led Groups and Committees and the Assurance & Learning Group reports to this forum on learning from events, trends and themes.

23.3 The Quality and Safety Committee is the statutory assurance committee and fulfils an assurance function in respect of ensuring that lessons are learnt from adverse events and that appropriate monitoring and examination of trends is occurring throughout the organisation.

23.4 The Legal Services Department will provide such ad-hoc reports as required by any Directorate or Department of the LHB upon request.

External Reporting Procedures

23.4 *Welsh Government*
The L&RS Solicitor will ensure that any claims exceeding the LHB's delegated authority of £1 million are reported to Welsh Government.

23.5 In addition, the Legal Services Department will monitor the nature and type of claims received to ensure that any claims which are novel, contentious or repercussive are reported in advance of settlement to Welsh Government and any required approvals are obtained at relevant stages. These may include claims, involving unusual and/or new features which if not correctly handled might set a precedent for other NHS litigation or which appears to represent test cases for potential claims actions or cases which although not formally part of a class action appear to be very similar in kind to concurrent claims against other NHS bodies. In such cases, the Legal Services Department will contact Welsh Government for advice regarding management.

23.6 *Welsh Risk Pool*
In addition, to the WRP Reimbursement Procedure, the LHB is required to notify the WRP as follows:

- WRP2 – during the course of the conduct of a claim that is being managed by solicitors other than L&RS when it becomes apparent that the value of the claims is likely to exceed £25,000.

23.8 *NPSA*
Where a claim, with an incident date post-dating 1st January 2004, has been identified as a patient safety incident but was not previously reported through the incident reporting process, the Legal Services Department will notify the relevant Directorate/Locality/Directly Managed Unit to ensure that a retrospective incident is reported which will be subsequently exported to the National Reporting and Learning System (NRLS).

24.0 Claims Review Procedure

24.1 The Welsh Risk Pool (WRP) is required to identify a minimum number of 30 claims for reimbursement made to the WRP for review within a financial year. The purpose of the review is to consider the manner in which the incident, concern and subsequent claim was handled by the Health Board, whether lessons were learned and practices made safer within all NHS organisations. The review may take the format of either a:

- Follow up Review: a follow up recommendation is made when there are particular issues around implementation of remedial action that the Advisory Board wishes to be clarified. The follow up will consider the action taken by the LHB in respect of the outstanding item. It may as a consequence focus upon the remedial action and monitoring set out in Part 2 sections 11 and 12 of the Appendix S Checklist but which was not formally in place at the time of the submission of the claims to the WRP.

- Claims Review: this review has a significantly wider scope than the follow up process. The Advisory Board having considered the claim have formed the view that there are aspects of the claims that would benefit from further review. It is likely to involve a detailed review of the circumstances and background to the claims with an analysis of remedial action and monitoring defined within sections 11 and 12 of the Appendix S Checklist. In addition it may be used to identify good practice which can usefully be disseminated across all NHS organisations in Wales. If there are residual uncertainties that prevent a recommendation to approve the claim being made, a review

can then be taken in respect of the aspect of the claims giving rise to any queries.

24.2 *The Initial Arrangements:*
Where the WRP wishes to undertake a claims review, the LHB will receive a letter addressed to the Chief Executive and copied to the Legal Services Department. The letter will contain:

- A request for information and documentation pertinent to that previously contained within the Appendix S at the time of the original submission of the claim.
- It will indicate whether the request is for a Follow Up Review or a Claims Review.
- It will identify whether the WRP Assessor is intending to undertake a site visit or a remote review.

24.3 The LHB will acknowledge receipt of the request within 14 days advising the WRP Assessor who will be the nominated point of contact for the effective operation of the review. This may include the provision of direct contact details for relevant members of staff involved in the review. The nominated contact may be a member of staff from the Legal Services Department or a member of staff of suitable seniority in the relevant Directorate/Locality/Directly Managed Unit.

24.4 The nominated contact will then proceed to collate or delegate responsibility for the collation of the documentation and information requested by the WRP Assessor. In the event of any difficulties retrieving or obtaining information, documentation or the co-operation of members of staff, the Legal Services Department will invoke the LHB's escalation procedure contained herein at section 25.

24.5 The documentation and information requested should be forwarded to the WRP Assessor within 1 calendar month of the date of the request. Where this cannot be achieved, the WRP Assessor should be contacted to agree a timescale for the provision of the information and documentation.

24.6 The WRP Assessor will contact the nominated contact to arrange a mutually convenient date and identify any staff who will be interviewed.

24.7 *During the Site Visit:*
In preparation for a site visit, the nominated contact should:

- Organise a location suitable for the Assessor and any interviewees for the conduct of the review which should include a plug point for laptops.
- Liaise with and arrange to escort the Assessor on arrival.
- Ensure all and any documentation required that has been previously communicated is available. This may include the claims file, patient records, policies, procedures/care pathways, and or audit.
- Ensure that all required interviewees are available for the period of the claims review and can be contacted and released for interview.

24.8 The nominated contact will be responsible for the safe return of all documentation to its rightful source.

24.9 *Reports:*

The assessor will draft the report and send a copy to the Legal Services Department for dissemination and comment to appropriate personnel, at the LHB's discretion. Any comments or discussion points or requests to amend the report should be forwarded to the WRP within 1 calendar month of the date of receipt of the report. In the absence of any comment within this time scale, the WRP will assume that there are no comments and will issue the report as final.

24.10 Following issue of the final report to the Chief Executive and Legal Services Department, the content is anonymised by WRP and reported to WRP Advisory Board. The Advisory Board will either accept the report with no further action or request a follow up in cases where further action is identified. Copies of the report will then be presented at the Concerns Network meetings. The LHB will ensure that this report is presented to the Assurance & Learning Group.

25.0 Escalation Procedure

25.1 In accordance with the strategic objectives set out in the LHB's Claims Management Policy, the LHB acknowledges the merits associated with the timely, prompt and thorough investigation of claims and supports the Legal Services Department in this process.

25.2 In the event that delays are experienced in obtaining a prompt or satisfactory response to a request for information, assistance or documentation, and all attempts at local resolution have been exhausted, the matter in the first instance will be referred to the Head of Risk Management & Legal Services and then as necessary to the Assistant Director of Nursing & Patient Experience. In the event resolution is still not possible, the Executive Medical Director and or the Director of Nursing & Patient Experience, should be notified for input and action.

25.3 It is the responsibility of the Legal Services Department, on the individual circumstances of each case, to determine what constitutes a reasonable timescale for or which comprises a satisfactory response and to advise the Executive Medical Director and Director of Nursing & Patient Experience accordingly.

25.4 The Head of Risk Management & Legal Services will agree with the Executive Medical Director/Director of Nursing and Patient Experience on an appropriate course of action and timescales for action. Where there is a direct costs consequence to the LHB, such as the imposition of a financial penalty by the Courts or the Welsh Risk Pool, the Directorate/Locality/Directly Managed Unit may be put on notice that such costs will need to be met from individual Directorate/Locality/Directly Managed Unit budgets. Such a step will only be taken with prior Executive approval and provision of written notice to the budget holder in question.

25.5 In the event of continued non-compliance, the matter will be referred to the Chief Executive for input and action.

26.0 File Closure

26.1 In conjunction with relevant personnel in the Finance Directorate, the Legal Services Department will ensure the completion of the File Closure process which includes:

- All staff involved to be contacted and be thanked for their involvement and assistance and notified of the outcome of the claim where this has not already been done by L&RS.
- Corporate Accounting informed of file closure.
- All records returned for safekeeping or copy records disposed of confidentially or sent for recycling.
- The file will be archived and a destruction date set.

APPENDIX A

ABM UHB – CLINICAL NEGLIGENCE	
Obtaining comments/initial investigation	NWSSP Legal & Risk Services have delegated authority to make contact with all medical staff without reference to Patient Feedback Team (PFT) and continue to correspond directly ensuring that copies of all comments received are provided to PFT. Requests for comments from nursing/midwifery/therapies/ancillary staff and for 'in-house overviews' to be directed via PFT at least in the first instance.
Instructing experts for condition, prognosis and other quantum reports.	NWSSP Legal & Risk Services have delegated authority
Identify all experts	NWSSP Legal & Risk Services have delegated authority (unless concerns previously noted)
Incurring fees for copies of notes to be obtained from other parties, hospitals or organisations and acquisition of a paginated bundle (preferably on CD) where that is necessary for the management of the case.	NWSSP Legal & Risk Services have delegated authority
Instructing Counsel and choice of Counsel	NWSSP Legal & Risk Services have delegated authority, however where a conference may be particularly costly or there are other management options available, this should be discussed if time permits.
Agreement to extend limitation	NWSSP Legal & Risk Services have delegated authority (please note that general moratoriums on limitation should be withdrawn prior to closure of a file).
Agreement to extend time for service of Particulars of Claim	NWSSP Legal & Risk Services have delegated authority
The filing of any interlocutory applications to court necessary to protect the Health Board's position or comply with directions (i.e. extension of time for service of Defence, reliance on expert evidence).	NWSSP Legal & Risk Services have delegated authority
Instructing a costs-draftsman and identity of same	NWSSP Legal & Risk Services have delegated authority

APPENDIX B

Documentation List

References & Legislation:

This Policy/procedure complies with the following: -

- The Civil Procedure Rules 1998
- WHC (97)/7- Clinical Negligence and Personal Injury Litigation-Structured Settlements
- WHC (97)/17- Clinical Negligence and Personal Injury Litigation- Claims Handling
- WHC (99)/128- Claims Handling Clinical Negligence Claims – Pre-Action Protocol
- WHC (2000)13-Risk Management and Organisational Concurrence.

Welsh Risk Pool Standard 5: Claims and any other relevant standards

Powys Local Health Board Adverse Incident Hazard and Near Miss Reporting Policy

Welsh Risk Pool Rules and Procedures

The LHB's Standing Orders and Standing Financial Instructions.

Powys Local Health Board Complaints Policy

Pre Action Protocol for the resolution of clinical disputes

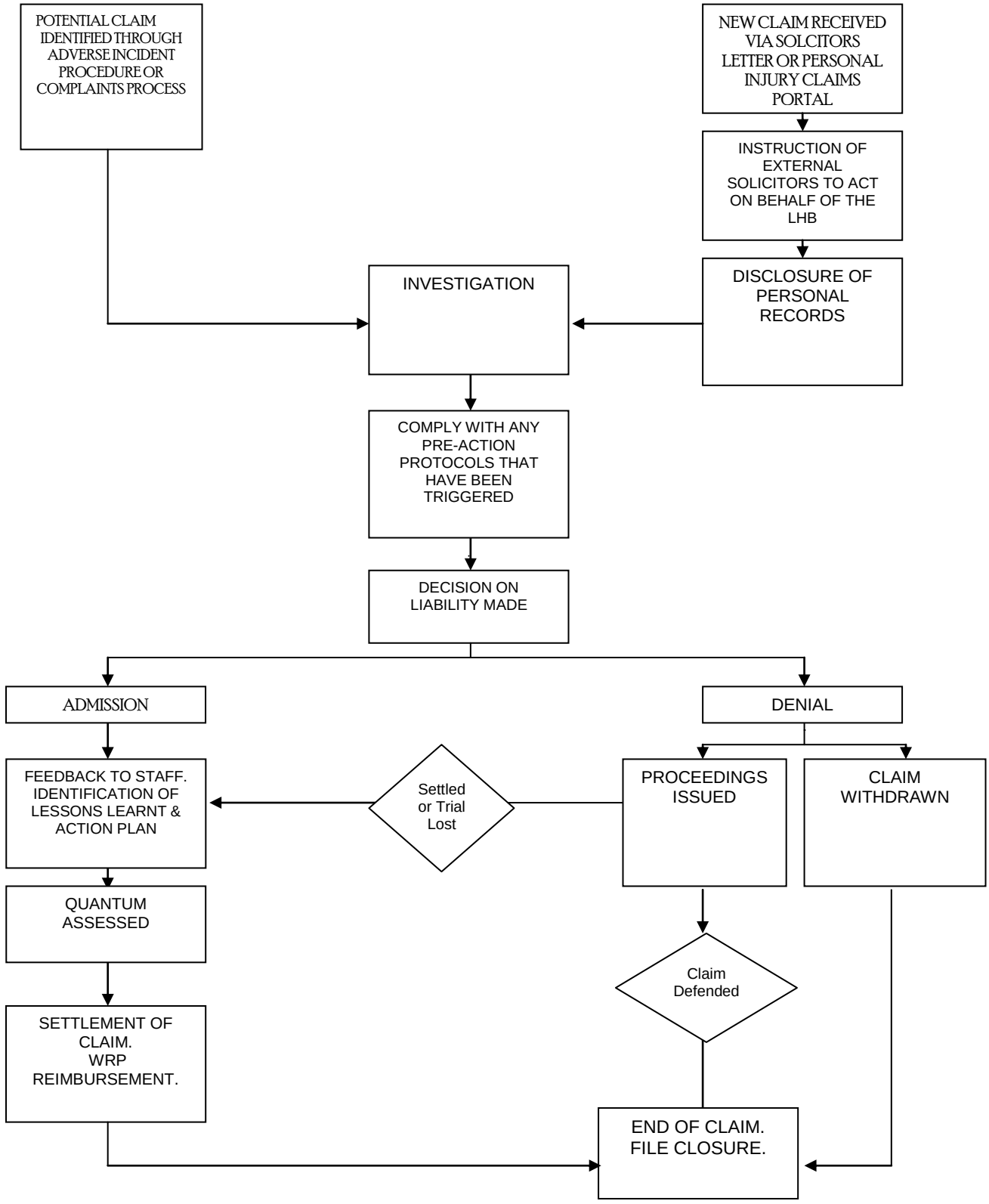
Pre Action Protocol for personal injury claims

Health Boards Risk Management Strategy

Health Boards Putting Things Right Policy

APPENDIX C

OVERVIEW OF THE CLAIMS PROCESS



APPENDIX D

Appendix S - Checklist for reimbursement following payment of financial compensation exceeding £25,000

FOR COMPLETION BY RESPONSIBLE BODIES MAKING A CLAIM

Checklist to be used when compiling the summary of a case – clinical negligence and personal injury cases whether settled by ex-gratia payments or by court order.

Responsible Body Name: Responsible Body Code: Case Reference: Laspar Ref: If relates to a SI – WG SI Reference No:
PART (1) INVESTIGATION, MANAGEMENT AND RESOLUTION
1.1 What were the circumstances of the originating incident? 1.2 What were the substantive allegations?
2.1 With reference to the allegations above, please give details or summarise the witness evidence of relevant witnesses/staff
3.1 What views (if any) have been obtained from any 'in-house' experts or non-treating clinicians? Please summarise 3.2 What external independent expert evidence has been secured? Please summarise
4.1 What were the failings or root causes identified? 4.2 What made the Responsible Body decide to dispose of the claim at this time?
5.1 What was the date and/or manner of acknowledgement that there was qualifying liability in tort?
6.1 Has appropriate legal advice been sought? Yes/No 6.2 If yes, from whom? 6.3 If no, why not? 6.4 If advice has been sought, what recommendations were made? 6.5 How were these recommendations followed?

7.1 By what means did the Responsible Body become aware of the concern/claim and/or how and on what date did the incident first come to the attention of the Responsible Body and what actions were taken?

7.2 Was the incident reported to the appropriate national organisation at the time (for example the NRLS or RIDDOR)

7.3 What was the date on which the concern was received?

7.4 Please confirm how the concern was investigated and managed pursuant to the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011? explain how the Responsible Body undertook its investigation and summarise the allegations made under Putting Things Right and include a copy of the root cause analysis undertaken under the Regulations

7.5 What was the date of Interim Report acknowledging qualifying liability?

7.6 What was the date of Final Report?

8.1 How was the value of the damages claim determined?

8.2 Have any factors appertaining to the handling of the claim or the course of the claim had any effect on either the damages or legal costs awarded in this claim?

8.3 Has any other insurer, third party or contributor been involved in making any payments in settlement of this case? Yes/No

8.4 If the answer is yes, please give details including any recommendations made, or apportionments agreed or any special conditions set by any third party.

8.5 Has the option of periodical payments been considered or have periodical payments been ordered? Yes/No

8.6 If not, why not?

8.7 If either, what was the outcome and why?

8.8 When did the NHS Wales Department of the Welsh Government approve the periodical payments settlement?

9.1 At what level within the Responsible Body has the proposed settlement been approved?

9.2 When was it approved?

9.3 Is this within delegated limits formally approved by the Board? Yes/No

9.4 If not, has the approval of the Welsh Government been obtained? Yes/No

9.5 If yes, on what date was approval obtained?

10.1 Does the case involve any novel, contentious or repercussive issues (e.g. could it set a precedent for other NHS litigation, or as part of a class action)? Yes/No

10.2 If it does, when was the NHS Wales Department of the Welsh Government informed and when?

10.3 Where applicable please give the details of the name and position of the person who forwarded this case for Welsh Government approval?

CLAIMS SPECIALIST'S DECLARATION

I have considered fully points 1 – 10 on this checklist and my findings are recorded. I confirm that the details recorded in each relevant section are complete and accurate and that these aspects of the checklist have been properly considered and actioned.

Signed by –

Print Name –

Position –

Date –

PART (2) RISK ISSUES AND LEARNING FROM EVENTS

11 Provide details of actions taken by the Responsible Body to learn lessons from any identified failings(Clinical, Health and Safety, Administrative or other) with a view to minimising or mitigating the risk or preventing the occurrence of this type of incident

12 What monitoring or audit measures have been introduced to ensure any improvements that have been implemented are working effectively? Please note that you may be requested to forward detailed monitoring reports relating to this claim at a later date to ensure all proposed improvements have been implemented completely and effectively and are reviewed on a regular basis.

13 What lessons can be learnt from this incident which would be of value to other Responsible Bodies or to the NHS as a whole?

GOVERNANCE DECLARATION

I have considered fully points 11-13 above inclusive on this checklist and my findings are recorded. I confirm that the details recorded above are complete, accurate and reasonable response to the failings identified. These aspects of the checklist have been properly considered and actioned.

Signed by –

Print Name –

Position –

Date –

PART (3) – RESPONSIBLE BODY DECLARATION AND AUTHORISATION

I confirm that the above details are complete and accurate and all aspects of the checklist have been properly considered and actioned. I agree that this payment offers the best value for money. I also confirm that:

Delete as appropriate

- This case is within the delegated authority of this Responsible Body and is not novel, contentious or repercussive. I, therefore, agree to this special payment.

- The Responsible Body has complied with its obligations and the conditions set out in Welsh Government Guidance to enable it to exercise its delegated authority to settle claims valued below £1 million

- The Responsible Body confirms that there have no material changes relevant to the exercise of the delegated authority since the date of the last WRPS Assessment

- This case is above the delegated authority of this Responsible Body/is novel, contentious or repercussive *(delete as appropriate)* and we have obtained advance formal approval to make this special payment from the Welsh Government

Signed by –

Print Name –

Position – CHIEF EXECUTIVE

Date –

Countersigned signed by –

Print Name –

Position –

Date –

Please note that this section must by signed by 2 senior officers of the Responsible Body both of whom must be authorised signatories and one of whom must be the Chief Executive in accordance with the delegated limits set by the Board

Send to: Head of WRP Services, Alder House, Alder Court, St Asaph Business Park, Denbighshire, LL17 0JL

APPENDIX E

Informal Claims Settlement Process