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**Annual Concerns**

**& Claims Report**

**2018-2019**

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**EXECUTIVE SUMMARY**

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

*2018/19 was the fifth year of the Patient Experience, Risk and Legal Services merging as one team with a focus on:*

* Individually acknowledging every complaint and the complainant, where possible, spoken to via telephone to discuss their complaint;
* Increased openness and involvement with the patient/family representative throughout investigations;
* Continuation of the “Lets Talk Campaign” which is designed for patients and staff to speak up and report concerns so that the Health Board can continually learn and improve the services we provide;
* Continual development of the Datix Web Risk Management Database to enable real time data and ensure it remains fit for purpose. This work has resulted in the Health Board being awarded reference site status in recognition of the development of the system and the Health Board has maintained this during 2018/19.

The Health Board received 1,356 formal complaints which is a slight decrease (0.73%) when compared to 1,366 complaints being received in 2017/18. Informal complaints have increased by 0.88% from 1018 received in 2017/18 to 1009 during the year.

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

**Communication** was the top theme for 2017/18 and remains the top theme for 2018/19. Communication accounted for 25% of the complaints upheld in 2018/19 a reduction of 4% when compared to 2017/18. The Health Board’s Patient Advice and Liaison Teams (working in Morriston Hospital, Princess of Wales Hospital, Neath Port Talbot Hospital and Singleton Hospital) are working with the Patient Experience Team to support work to reduce the number of complaints for communication issues.

Action being taken to reduce communication concerns include:

* **Training** for staff focusing on the Five Star presentation incorporating communication, Health Board values and the three domains of Patient Experience. These standards are set out in: *Key Determinants of a Good Service User Experience* which are based on national and local published evidence.

Attendees at these sessions are staff in a position to drive the initiative back at the workplace. Each training event lasts up to 1.5 hours and is interactive and assists staff in star rating their own ward or department against *Key Determinants of a Good Service User Experience.* To achieve this, the trainer designed a bespoke document that also included the Health Board’s Values Framework. Feedback from these sessions has been very positive. A number of bespoke sessions were held in 2018/19. In the main these were provided under the heading of Customer Care with a clear focus on communication skills and further sessions will be held in 2019/20.

* **Reviewing the roles of the Patient Advice Liaison Service (PALS) Officers** to focus on early resolution of communication concerns.
* **Analysis of themes of communication concerns** to enable an inpatient plan to be developed.

**Clinical treatment** was the second highest theme with 22% of complaints in this theme, with the majority relating to delay in receiving treatment, which was an increase of 5% when compared to 2017/18.

**Access/Discharge** was the third theme of the most upheld complaints with 12% of complaints upheld. Improving this area of our services is a priority for the Health Board to take forward and a number of actions are being taken to improve performance. While there has been some improvements in terms of reducing the number of patients waiting to start treatment and number of people waiting over 36 weeks, the Health Board recognises that further work is required to reduce the waiting times further and the Board is taking action in this respect. Improving access to services for patients remains a priority for the Health Board.

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

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

* No new public interests (Section 16 / 17) Ombudsman Reports received in 2018/19 and the last report was received in 2015/16.
* No Regulation 28 reports were issued by Her Majesty’s Coroner in relation to inquests involving the Health Board where the Coroner recommended action to prevent future deaths occurring compared to four in 2017/18. Please see section 18 for more details of these reports and the action the Health Board has taken.

All concerns provide an opportunity for learning and they are a valuable method of us knowing where we can improve. We want to reduce these wherever possible and to give patients and our staff a service they can be proud of. Section 13 of this report provides details of an example of lessons learned/actions taken to help minimise recurrence following investigations of concerns.

The report sets out the organisational arrangements for the management of concerns and the number of cases managed within the period. Setting this information against the number of patient contacts we have as an organisation demonstrates that complaints and incidents are rare and that the vast majority of the people we see are satisfied with the care and treatment the Health Board provides. Supporting this statement the percentage of patients who would highly recommend the Health Board Services to Friends and Family in 2018/19 was 95%.

1. **Background to the NHS Redress Regulations 2011**

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

These Regulations require a proactive approach to acknowledging and putting things right when patients have suffered harm or poor experience. They were designed to streamline the handling of Concerns. Under the new *Putting Things Right* arrangements, ABMU Health Board has improved its performance against the principles of the guidance, to "investigate once, investigate well", ensuring that concerns are dealt with in the right way, the first time round.

1. **Arrangements for the handling of concerns**

The Health Board’s Non Officer Member who has oversight for the handling of concerns in 2018/19 was Mr Martyn Waygood and is also the Chairman of the Quality & Safety Committee. Mr Waygood’s role is to ensure the Board is provided with an appropriate level of assurance in respect of managing concerns.

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

In 2018/19 revised management arrangements were implemented with six Directly Managed Units replacing the eleven Directorates and Localities management arrangements. Each of these Units has in place a Quality and Safety Team who investigate their incidents and complaints (concerns). The focus of the Units is responding to concerns with quality, timely responses, ensuring shared learning across the Units as a priority. The Patient Experience, Risk and Legal Services Team support the Units in terms of strategic direction and performance management to improve the quality of responses to complaints and improving the timeliness of the responses issued.

**4. Concerns - Safety Incidents**

A total of 26,776 incidents were reported during the year the majority of which related to no harm incidents (73%). The degree of harm and level of harm is provided in Table 2.

Table 2

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Table** | **Green** | **Yellow** | **Amber** | **Red** |
| Incident Reported Date | **No/V Low Harm/ Damage** | **Minor Harm/ Damage** | **Moderate Harm/Damage** | **Severe/V Severe inc Death** |
| **2008/2009** | **69.89%** | **25.63%** | **3.47%** | **1.00%** |
| **2009/2010** | **72.00%** | **25.45%** | **1.80%** | **0.76%** |
| **2010/2011** | **75.92%** | **21.40%** | **1.84%** | **0.77%** |
| **2011/2012** | **87.60%** | **10.60%** | **1.02%** | **0.68%** |
| **2012/2013** | **89%** | **8.50%** | **0.98%** | **0.74%** |
| **2013/2014** | **89%** | **8%** | **1.56%** | **0.66%** |
| **2014/2015** | **84.42%** | **13.04%** | **2.18%** | **0.35%** |
| **2015/2016** | **81.7%** | **14.6%** | **3.2%** | **0.32%** |
| **2016/2017** | **80%** | **17%** | **3.3%** | **0.34%** |
| **2017/2018** | **77.97%** | **18.80%** | **3.25%** | **0.30%** |
| **2018/2019** | **73%** | **24%** | **3%** | **0.1%** |

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

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

1. **Serious Incidents**

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

During the year, 318 serious incidents were reported to Welsh Government, these included pressure ulcer incidents, reports of bed closures due to outbreaks of infection within our hospitals.

ABMU introduced a standard operating procedure for the investigation of never events and serious incidents in January 2015, which was reviewed and updated in 2015/16, to ensure rapid investigation and reporting of never events, resulting in timely actions being taken and learning within the Health Board. The protocol was further reviewed in 2018/19 and a Serious Incident Toolkit developed and implemented.

**5.1 Never Events during 2018/19**

During the year one incident occurred which was a ‘Never Event.’ They are incidents that all NHS organisations should have robust systems and processes in place to prevent them occurring. The incident has been fully investigated and as a result changes have been made to improve patient safety. The event related to wrong site surgery.

The Health Board accepts that never events should not happen and has taken action as a result of the findings in the investigation report and shared these with the patient involved. The learning from this event includes:



1. **Concerns – Complaints**

Complaints can be received at any place across the organisation, and not all complaints are resolved using the formal process. The Health Board is required to report performance against compliance with the timescales recommended within the NHS Redress measure and via the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. A grading system is in place which considers the severity of the concern to promote a suitable level of investigation to be undertaken.

Concerns graded-

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

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

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

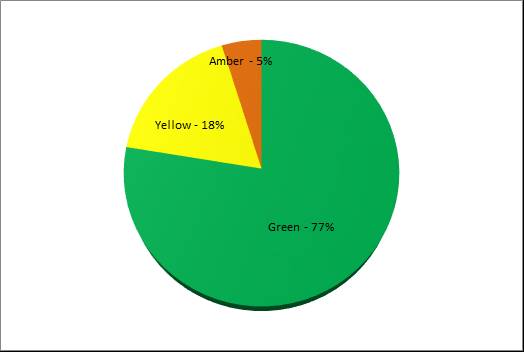
**6.1 Developments lead by the complaints team include:**

* The Health Board continues to work with external stakeholders eg the Community Health Council (CHC). The Deputy Head of Patient Experience and Concerns holds regular meetings with the Deputy Chief Operating Officer to improve and develop working relationships. The aim of the meetings are to jointly review the CHC complaints sent to the Health Board to share information, identify trends and to support good working relationships between the two organisations. During 2018-19 there has been a considerable reduction in the number of escalation process by the CHC due to the continuing close working relationship with the external stakeholders.
* The Corporate Patient Experience & Concerns Trainer, as a consequence of the continuing theme of Communication in complaints upheld, concentrates on delivering  training for staff on “nipping complaints in the bud”. Also the training covers behaviours and behavioural change. Bespoke training sessions for areas identifying continual themes of communication have been completed across the Health Board.
* A Concerns and Redress Assurance Group is in place to audit and monitor complaint response compliance from the 6 Service Delivery Units and meets on a monthly basis. Feedback and learning form this Group. Terms of Reference of CRAG have been reviewed and representatives from the Units are invited to attend peer review meetings to focus on continuous improvement and learning.
* Workshops and training has been delivered to support the Service Delivery Units in the management of concerns and redress cases. The workshops promote an ethos for good investigation of complaints and complainant responses and the importance of timely responses. The Ombudsman Improvement Officer has also presented at these workshops. The workshops complement the Mental Health and Learning Disability Service Unit Improvement plan and provide for staff the tools to respond to complaints in line with the Regulations. Specific training requested by Mental Health Senior Staff has been held.
* The Health Board continues to operate a process with the aim of contacting complainants on receipt of a concern, and a meeting offered to the complainant. Complainants are now updated regularly on the progress of the complaint.

**6.2 Complaints – Activity and Performance**

During the financial year of 2018/2019 the Health Board received 1326 formal and 1018 informal concerns totalled 2344 for the year.

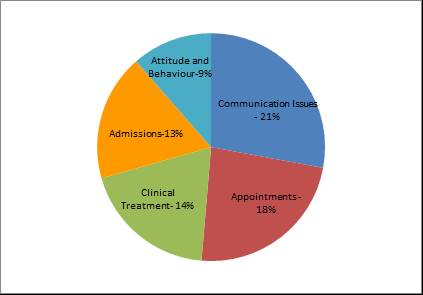
Below is a pie chart which shows the percent of complaints by grades received during 2018/19.



**6.5 Type of Complaint Received**

The top five types of formal complaints received are provided in the pie chart below, 21% relate to communication issues.

**Top 5 complaint themes**



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

The Health Board’s compliance with those concerns expected to achieve a response within 30 working days was 82% (average) in 2018/19 achieving the Welsh Government target of 75%. The Health Board will aim to sustain performance in 2019/20.

**7. Compliments**

A total of 1,621 compliments were recorded in 2018/19. Compliments recorded include: formal letters/correspondence expressing gratitude and appreciation for treatment.  Many more cards, letters, and gifts were also sent directly to clinical teams and wards from grateful patients and relatives, which have not been formally recorded.

Examples of compliments received during 2018/19 include:

**Singleton Hospital Delivery Unit:**

“I write with regard to my elderly mother’s care in the Eye Surgery Day Unit. She had one cataract removed but then became seriously ill, delaying her second cataract operation until now. On both occasions the care that Mum received was outstanding, not just in terms of clinical excellence but also the kindness, personalised care and accommodation of her sensory issues with both vision and hearing. The compassion, support and expertise shown by your staff in that Unit moved Mum to tears and we are privileged to have a health service which gives us all such care free at point of delivery”.

**Morriston Hospital Delivery Unit**

*“As a family we would like to commend the staff of Ward A at Morriston Hospital for the excellent care and treatment that they provided for my father.*

*Staff guided us through his operation and recovery treatment answering any questions, giving time to advise us. The staff supported us and the whole team worked with the same ethos providing the best care possible for the patient. The staff brought positivity during a very worrying time for our family. My father was treated with dignity and respect thus providing him with care of the highest standard”*

**Mental Health and Learning Disabilities Delivery Unit:** *“Just wanted to say that the CBT course that you have put on in ARC centre has been amazing for my daughter. As a single parent who has had to deal with anxiety and depression for a child, the difference the past 2 weeks, are just well let me say changing. Please pass back feedback in to your team, from a parents point of view, I no longer have that sick feeling when the phone rings and it’s my daughter. Amazing course, amazing work”.*

**Neath Port Talbot Hospital Delivery Unit:**

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

The teddy made her day”

**Princess of Wales Delivery Unit:**

*“We wanted to send a big thank you for the care our mother  received during her stay on Ward  2  from January to May this year. Mum has a very strong character and great determination which is partly why she has managed to move on from Ward 2 however, her unexpected recovery is also testament to the care she received from you and your staff.”*

*‘***Primary and Community Services Delivery Unit - Community Resource Team:**

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

1. **Referrals to Public Service Ombudsman (PSO) for Wales**

During 2018/19 the Ombudsman saw an increase in complaints being referred when compared to 2017/18.

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | **2016/17** | **2017/18** | **2018/19** |
| Complaints referred to the PSO | 96 | 121 | 139 |
| Number of complaints PSO investigated | 26 | 37 | 35 |
| % of cases upheld in full or part or voluntary settlement | 25% | 42% | 38% |

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

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

**9. NHS Redress**

Under the NHS (Concerns, complaints and Redress Arrangements) (Wales) Regulations 2011 arrangements, the Health Board is required to identify those complaints where the investigation finds that harm has been caused because of a breach of duty of care.  In these cases, the Health Board is required to offer Redress to the person, which can comprise of :

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

Due to the nature of the Redress process whilst these concerns will have had a response, consideration of Redress or acceptance of the Redress Offer was ongoing at the end of the year and will be resolved during 2019/20.

Training on redress continues with the Legal Services Team providing training to Directly Managed Unit teams as part of Managers training on the Managing to Deliver Programme on a quarterly basis and six monthly to clinicians on the Consultant Development Programme.  In addition Concerns and Redress Workshops have been held during 2016/17, 2017/18 and 2018/19 to support the Units in complaints and redress management.

1. **Patient Experience**

The Patient Experience Unit continues to provide support and guidance to the Delivery Units (DU) on increasing the number of patient feedback surveys completed and has been involved in the following developments during 2018/19:



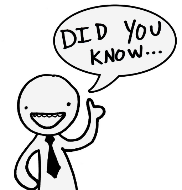
**Five Star Patient Experience:** The Five Star Patient Experience training is still a priority of the Board, and several training events have taken place and more sessions are planned.  Wards/departments who have attended this training have seen an increased response rate to the Family and Friends Test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

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



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



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

1. **Claims**

In addition to those cases settled under the Redress process, the Health Board continues to receive new Clinical Negligence and Personal Injury Compensation Claims.  During 2018/19, 211 Clinical Negligence Claims were received compared to 195 claims received in 2017/18 (8.2% increase) and 183 claims were received in 2016/17.

The Health Board also received a total number of 57 Personal Injury Claims in 2018/19 compared to 62 cases received in 2017/18 and 56 in 2016/17.

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

* Failure/insufficient/incomplete monitoring
* Delayed diagnosis
* Inappropriate/aggressive behaviour to staff by patients
* Slip/Trip or fall

**10.1 Priorities for improvement (Claims Team)**

During 2018/19 the following actions were taken to continuously improve the service provided:

* Claims Policy and Procedure updated
* In addition to a handbook to assist internally, The Claims Team compiled a PTR leaflet which is designed to assist (external) complainants in the next steps of the investigation, which is sent out with every introductory redress letter
* The Claims Team’s Standard Operating Procedure Manual/Standard Operating Procedures for use within the Department to enhance training of staff within the Team and continuity in the management of claims, inquests and redress cases were reviewed and updated
* The Health Board delivered Well Being sessions for staff within the Patient Feedback Team to assist in coping with the nature of the work that is being dealt with on a daily basis.
* The Claims Team continue with Peer Reviews to provide support to staff and share complex cases with a view to sharing knowledge, learning and enhancing education and training.
* The Claims Team developed and continue to promote and foster good communication links with the Units.
* Lawtel subscription has been renewed and all relevant staff have been trained to support the research when quantifying redress claims.
* Introduction pack developed for newly appointed staff has been reviewed and upheld.
* Internal Audit on Claims Management confirmed substantial assurance with no actions identified (green rating).
* Regular meetings with Mental Health & LD governance team have been set up to review and prioritise inquests / claims / redress
* PTR training has been provided to the Mental Health & LD team (by both Legal & Risk and the Claims Team)
* Inquest training provided to the Claims Team by Legal & Risk Services, which in turn has prompted development in the teams process and guidance sent out to staff when requesting statements for an Inquest matter
* All units were visited by the Redress team to introduce and support hem with the new Welsh Risk Pool Reimbursement changes introduced in 2019
* A survey was produced by the Redress team early 2019 to obtain feedback from units across SBUHB on the changes introduced to the team in 2018; results were very positive
* All staff receive regular 1:1 meetings with senior staff to discuss cases and weekly redress meetings with senior staff are ongoing to support case handlers
* Staff in the Claims team attend training sessions provided by Legal & Risk Services and Welsh Risk Pool

**Actions to be achieved in 2019/20**

* Update the Inquest process for requesting and supporting staff
* Consolidate and enhance the management process for Claims WRP Reimbursement process
* Successfully manage competing priorities as a result of the WRP reimbursement process
* Further training on claims management and inquest provided to the Claims team
* Claims team to undertake further learning sessions in units to educate staffs who engage with claims / inquest/ PTR process
* Job descriptions to be updated.

1. **Learning Lessons**
   1. **Learning Lessons/Actions Taken relating to Claims**

The Health board and healthcare team have been successful in a bid to Welsh Government for additional resources for mental health services in HMP Swansea. The additional resources are being used to develop a crisis and mental health intervention team. The new team will work closely with the healthcare core team of mental health nurses and the Secondary care mental health In-reach service.

Maternity - Standard Operating Procedure developed on documentation for perineal suturing which has been devised in all Midwifery led areas



A Local Safety Notice was issued in 2019 in light of the Supreme Court’s ruling on ***Darnley v Croydon NHS Trust (2019)*** which found that there is a duty on non-medical staff to take reasonable steps to provide accurate information including the time within which medical assistance is likely to be available to a patient. Advisory action included provision of such information by leaflet or prominent notice board.

A Cavity Wound Dressing Care log has been created to track the date, number and type of dressing used and also what is removed, to improve the process around ensure all packs are removed

More robust processes around swabs, instruments and needle counts. This includes a revised SOP to account for a change in practice: two staff responsible for swab count and check process. In addition, a further change in practice; all chest and cavity swabs are now recorded on one swab board. This will ensure that the scrub nurse has more control of all the swabs in use during surgery. New swab boards have also been purchased.

1. **Next Steps**

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

* **The Concerns and Redress Group**: will continue to meet monthly. The Group reviews a minimum of 10% of closed concerns/redress cases across the Units on a monthly basis and undertake deep dive reviews into Unit responses on a rotational basis. The Terms of Reference are currently being reviewed to consider including auditing Ombudsman action plans.
* **Concerns & Redress Workshops**: held annually since 2016/17 for the Units facilitated by the Patient Experience, Risk & Legal Services Team which included; how to investigate and manage complaints ensuring compliance with the Concerns Regulations and values based responses, will continue in 2019/19
* **Training Needs Analysis** to be completed for Corporate and Unit staff who investigate and manage concerns and training plans updated as a result.
* The **Ombudsman Improvement Officer** – the Health Board will meet regularly with Officer to monitor and take action at the earliest stage in relation to improvements and learning from these concerns.
* **Workshop with the PALS and PEAS teams:** During June 2018 all the PALS/PEAS staff members and the Governance Managers attend a Corporate Workshop with Non Officer Member/Chair of the Quality and Safety Committee and Deputy Director of Nursing and Patient Experience. The workshop was an opportunity to recognise the excellent work the teams are doing across the hospitals and also establish priorities to take forward consistently across the Health Board. Future workshop are being planned.
* **Training:** Customer Care training with a clear focus on communication skills. In addition a pilot project has been proposed for working with staff who have a responsibility to deliver life changing news to both patients and their relatives. This training will also support *all other staff* working in an environment where life changing news has been given.  This pilot is driven from a search of the data where patient/relatives felt they could have been better supported during such distressing circumstances. To achieve this the trainer will write bespoke sessions focusing on the need for sensitivity and the value dignity, empathy and compassion play in such situations. The trainer will use a variety of activities including role play and group discussion.

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

1. **Conclusions**

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

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

**Appendix 1**

**Definitions**

CLAIM Legal perusal of action against a party to compensate for losses incurred.

CONCERN A complaint, a notification of an incident concerning

patient safety or a claim for compensation.

COMPLAINT Any expression of dissatisfaction.

INCIDENT Any unexpected or unintended incident, which did

lead, or could have led to harm for a patient.

NON-OFFICER MEMEBER A member of the Board who is not an employee

of the Health Board.

OFFICER MEMBER A member of the Board who is an employee of the Health Board.

PATIENT The person who received or has received services

from the Health Board.

PUBLIC SERVICES

OMBUDSMAN FOR WALES If a person raising a concern remains dissatisfied after raising a concern with a Health Board, they can request an independent review by the Public Services Ombudsman for Wales (PSOW).

PUTTING THINGS RIGHT Guidance produced by Welsh Government for the NHS in Wales to enable health organisations to handle concerns in accordance with the NHS Redress Regulations.

REDRESS Redress relates to situations where the patient may have been harmed and that harm was caused by the NHS in Wales. Redress can comprise of:

* a written apology;
* a report on the action which has or will be taken to prevent similar concerns arising;
* the giving of an explanation, and
* the offer of financial compensation and/or remedial treatment, on the proviso that the person will not seek to pursue the same through legal action.

QUALIFYING LIABILITY Where a Welsh NHS body has BOTH (1) failed in its duty of care to a patient, and that the breach of duty of care has been (2) causative of the harm that the person has suffered. It is only when both these tests are satisfied that a payment of compensation under the NHS Redress Regulations should be considered.