AGENDA ITEM
4.2

CTM BOARD

PATIENT EXPERIENCE AND PATIENT SAFETY REPORT

Date of meeting	30-1-2020
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Ruth Friel, Head of Patient Experience Kellie Jenkins Forrester, Senior Manager for Investigations and Quality Improvement Mark Townsend Head of Clinical Informatics and Audit
Presented by	Executive Director of Nursing, Midwifery and Patient Care
Approving Executive Sponsor	Executive Director of Nursing, Midwifery and Patient Care
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Quality & Safety Committee	14/01/2020	NOTED
Management Board	16/01/2020	NOTED

ACRONYMS	
PSOW	Public Services Ombudsman Wales
POW	Princess of Wales
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
HON	Head of Nursing
TVN	Tissue Viability Nurse

1. SITUATION/BACKGROUND

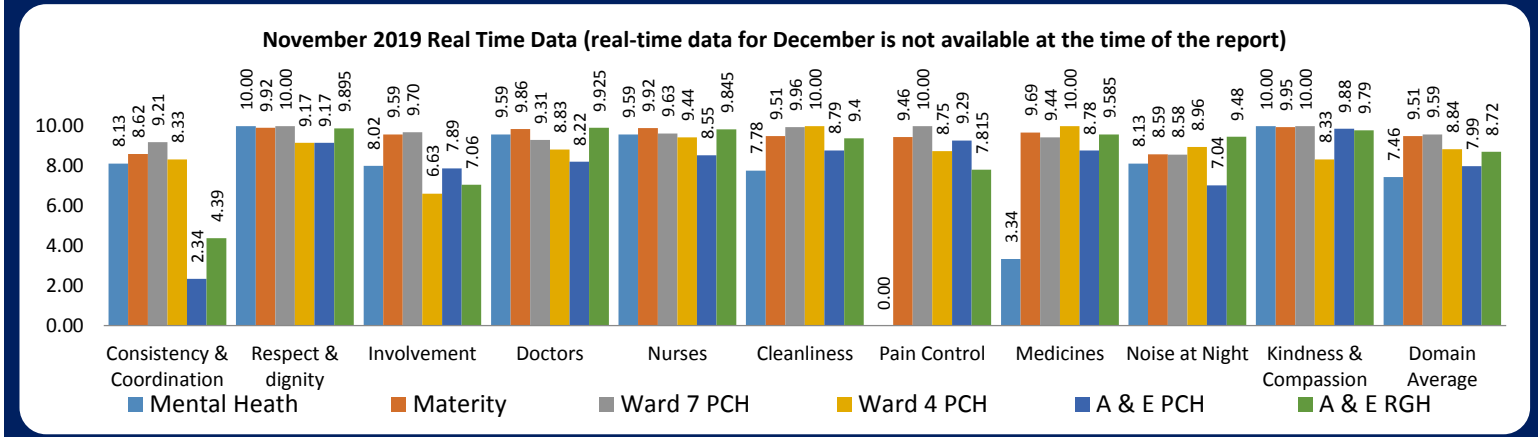
The purpose of this report is to provide the Board with a summary of patient experience and concerns, including complaints and patient safety incidents, from 1 November 2019 up to 31 December 2019.

The report includes serious incidents reported to Welsh Government and the current position of patient safety incidents and non-compliance with Patient Safety Solutions notices and alerts is also included. *(Refer to section 3, page 5 for summary of key risks and mitigating actions taken).*

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

Section 1: *Patient Experience*

	Consistency & Coordination	Respect & dignity	Involvement	Doctors	Nurses	Cleanliness	Pain Control	Medicines	Noise at Night	Kindness & Compassion	Domain Average
Maternity	8.62	9.92	9.59	9.86	9.92	9.51	9.46	9.69	8.59	9.95	9.51
Ward 7 PCH	9.21	10.00	9.70	9.31	9.63	9.96	10.00	9.44	8.58	10.00	9.59
Ward 4 PCH	8.33	9.17	6.63	8.83	9.44	10.00	8.75	10.00	8.96	8.33	8.84
A & E PCH	2.34	9.17	7.89	8.22	8.55	8.79	9.29	8.78	7.04	9.88	7.99
A & E RGH	4.39	9.89	7.06	9.92	9.84	9.4	7.81	9.58	9.48	9.79	8.72
Mental Heath	8.13	10.00	8.02	9.59	9.59	7.78	0.00	3.34	8.13	10.00	7.46



Positive Comments

73% *of total feedback received*

Fantastic, outstanding, amazing staff.
Could not have asked for better care.
Midwives & HCA's brilliant. HCA's don't get enough praise.
Everyone has been really lovely on the ward.
Midwives are very supportive.
Staff are very busy on the ward, but doing their best with what they can.
10/10 service
Recommend the department 100%
Staff have been lovely and so kind

Negative Comments

27% *of total feedback received*

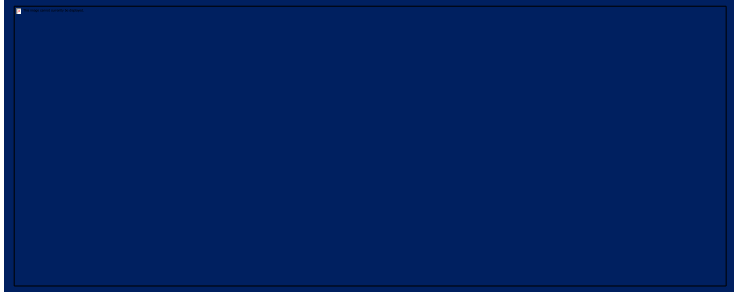
Staff breaks are being cancelled due to the extreme pressure.
No beds / trolleys available on the department.
Contradictory information provided regarding next of kin advice.
Toilet door handle of the communal toilet was dirty
Noise from staff at night - slamming doors and using noisy trollies
No compassion from staff.

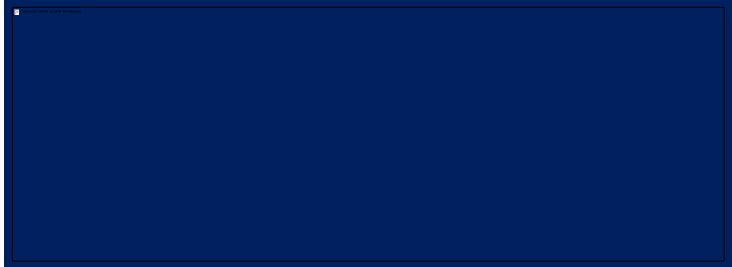
Patient experience feedback is shared with staff via departmental and unit meetings and also at corporate level via the concerns scrutiny panel, the patient experience and quality, governance and learning subcomittees of the Quality and Safety committee.

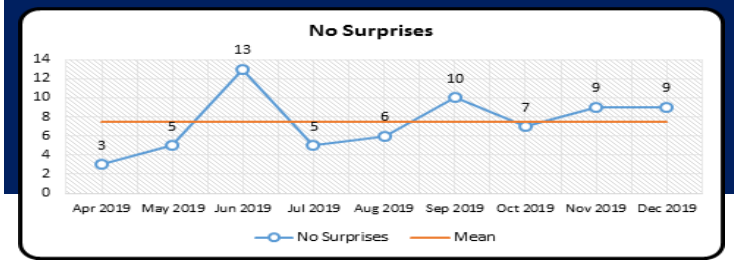
Positive feedback is also shared with individuals and some feedback is placed on the hospital TV's.
There is a bi monthly 'Listening and Learning' Newsletter shared with staff groups and also placed on the intranet.
http://ctuhb-intranet/News/Shared%20Documents/Listening%20%20Learning%20From%20Feedback%20December%202019%20v4%2019-12-2019%20(003).docx?web=1

Immediate Actions:
Positive comments have been fed back to staff.
Housekeeping notified regarding extra cleaning.
Managers discussed negative staff attitude with individual staff.
Staff reminded on the importance of creating a peaceful environment at night.
A&E Manager aware of the situation with the ambulances, long waiting times and trolleys in the corridor and are managing the department using the agreed escalation processes.

Section 2: *Serious Incidents*







* Incidents by top 3 sites excludes Mental Health, Obstetrics & Gynaecology, Paediatrics, CAMHS and Therapies (to enable site comparison).

Serious Incident

There were 69 Serious incidents reported to Welsh Government during November and December of which, 2 were classified as Never Events and both occurred in November. Both relate to the wrong side anaesthetic block and occurred in POW, investigations are ongoing. The categories with the highest number of Serious Incidents relate to falls and delays.

No Surprises
The chart shows 18 cases for November and December 2019 and the categories are identified within the chart. Review of the data reveals no trends or themes in the incidents.

All Patient Safety Incidents
Slip, Trips & Falls and Pressure Damage were the two highest reported incidents. The highest number of falls were reported in Older people's mental health service and community hospitals.
There were no real differences in the incidence of pressure damage across the 3 DGH sites with PCH reporting 127, RGH 112 and POW 107.

- **Falls Improvement Work**
  The new national Falls documentation will be rolled out W/c 24th February 2020 which is

No Surprises by Category	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Staff related including behaviour and performance	4	3	1	0	1	0	1
Patient related	1	1	2	2	2	6	3
Service related including staffing	5	1	0	1	0	2	2
Media reporting	1	0	0	0	0	0	0
Information sharing / documentation / communication	1	0	3	1	1	1	0
Environmental including infection	1	0	0	3	2	0	3
Delays	0	0	0	3	1	0	0
Totals	**13**	**5**	**6**	**10**	**7**	**9**	**9**

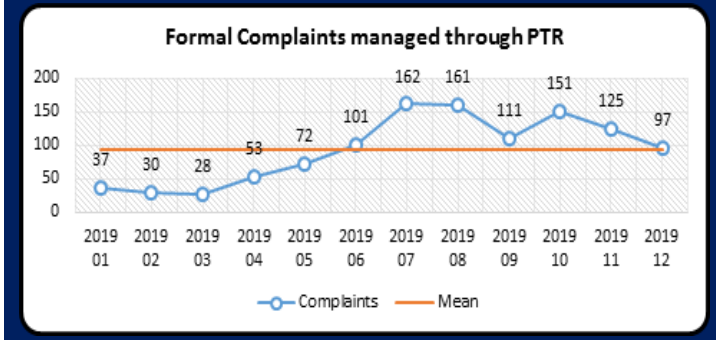
National Falls Awareness week. The roll out includes training and revised enhanced supervision for those at risk of falls.

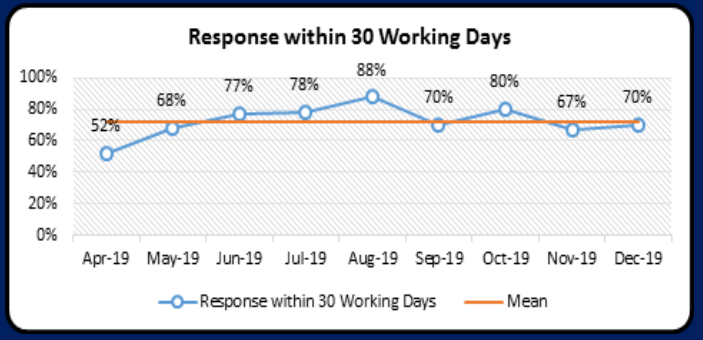
- **Pressure Ulcer Improvement Work**
  The Heads of Nursing chair weekly scrutiny panels with ward managers. TVN's are updating the pressure ulcer reporting policy to ensure it reflects All Wales recommendations and there is consistency with reporting.

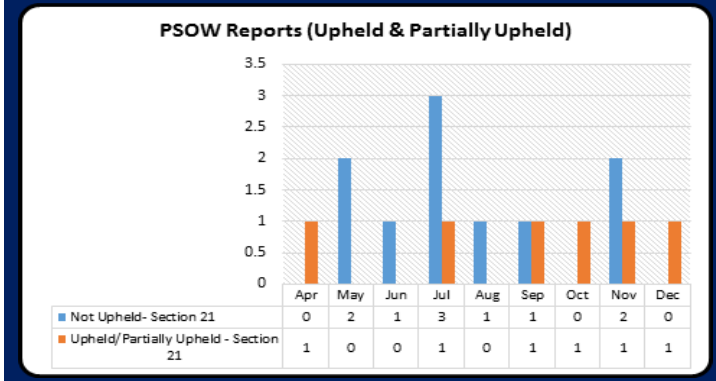
Incidents by Top 3 Sites (excludes other areas)

Out of the total number of incidents, the 3 sites with the highest reporting are identified as the 3 DGH sites. The data identifies a difference in reporting; with the Princess of Wales Hospital consistently higher than the remaining sites. Moisture Lesions and 12 hour Breaches are reported by POW, but not by PCH and RGH. Work is ongoing for consistent reporting on Datix across all areas.

Section 3: *Complaints, Inquests and Patient Safety Solutions*







PSOW new powers which are coming in to force which includes:

- Authority to accept oral complaints
- Own initiative investigations if there is an apparent trend/ theme
- Power to investigate private/nursing care homes

Information will be available on the PSOW site in January 2020 and the enclosed power point is available now. https://www.ombudsman.wales/publications/

The PSOW upheld 2 complaints in November and December. One related to record keeping in gynaecology services and the other related to complaints handling with concerns raised regarding the quality and response time.

The number of reopened complaints during November was 8 and 5 in December in comparison to 6 reported in October 2019. These included:

- YCC (2)
- RGH (4)
- PCH (5)
- POW (2)

The number of referrals to the PSOW requiring investigation are reducing from 37 to 33%.The All Wales average is 42%. However, of those cases which were investigated, a greater number were upheld (in whole or in part).

Two Inquests concluded in November which resulted in a Regulation 28 report. The first report relates to a process for managing the cancellation of appointments within Mental Health Services. The second report relates to a system for monitoring oxygen for patients who left unaccompanied and dependent on a finite supply. No reports were issued for December.

Formal Complaints

Validated data has shown that the Health Board received 97 complaints which have been managed under Putting Things Right. Also there were 252 complaints dealt with via Early Resolution.

November and December shows a decline in Complaints reported with the most significant improvement being a decrease in the number of complaints related to delays, admissions and discharge issues.

Response Times

The response times for Complaints being closed within 30 Working days is 67% in November and 70% December.

Clear differences in response times is noted between PCH, RGH and POW with POW consistently being above 85%. The new organisational structures will mirror the structure already in place in POW which should improve the quality and timeliness of responses. Escalation is now through the service managers.

Common Themes

- Delayed follow up
- Lack of Nursing observations, supervision and pain assessment
- Communication especially regarding treatment plans and care pathways, e.g. DNAR plan.

Learning from Concerns

Substantial focus on waiting list management
Targeted nurse training and enhanced supervision in areas of concern
Reflective discussions via 1:1's with medical education supervisors/ CD's

Non-Compliant - Patient Safety Solutions (PSS)
(All listed PSS are RED due to non-compliance or partial non-compliance across the organisation)

Performance for all Health Boards and Trust in Wales can be found at http://www.patientsafety.wales.nhs.uk/safety-solutions-compliance-data

PSN008 **Nasogastric tube misplacement: continuing risk of death and severe harm**.	**PSN030** **The safe storage of medicines: cupboards.** Areas of non-compliance have been identified. A paper identifying the actions taken by the Health	**PSN046** **Resources to support safer bowel care for patients at risk of autonomic dysreflexia.**

CE strips non –marked are being used within the HB with WG agreement as it is an All Wales procurement issue. Risk being managed through training, revised guidance and audit.	Board to mitigate the risk is scheduled for presentation to the Quality & Safety Committee in February 2020.	Health Board policies and procedures are being reviewed and a Standard Operating Procedure is being developed – anticipated completion date March 2020.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD

3.1 The complaints response times within 30 working days are 67% and 70% consecutively for November and December 2019. The Princess of Wales site has a consistent response rate of above 85%. The POW's units and service level governance structures are mature and the revised structures in the other units will assist with the required changes in concerns management. An improvement plan is in place and weekly monitoring is in progress. A revised Concerns policy has been drafted and is going through approval process.

3.2 Concerns with the quality of medical child protection assessments have been reported and there is ongoing improvement work to ensure required standards are met.

3.3 There were 2 Never Events in POW in November, both relating to wrong site anaesthetic blocks. The Root Cause Analysis (RCA's) are ongoing which will identify any further required action following the immediate make safe actions put into place at the time.

3.4 Harm reviews for service users where their Follow Up is not Booked (FUNB) is ongoing and the concerns team are working with Legal and Risk services for advice with Duty of Candour and Redress.

3.5 A number of dental referrals to secondary care had been delayed or not received, the reasons for the delay are being investigated and it is linked with the introduction of the E Dental referral system. The investigation is being supported by the patient safety team. The initial harm review has not identified any harm and the reviews are ongoing. The reviews are also being undertaken for community dental services and the dental training unit.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	This report concentrates on quality of care, patient safety, and patient experience.
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below: The work reported relates specifically to Standard 3.1 Safe and Clinically Effective Care, and Standard 6.3 Listening & Learning from Feedback.
Equality impact assessment completed	No (Include further detail below)
	Concerns are managed within the framework of Putting Things Right, ensuring that all issues are dealt with equitably. There are no specific implications relating to equity and diversity within this report
Legal implications / impact	Yes (Include further detail below)
	Concerns are managed in accordance with the National Health Service (Concerns, Complaints and **Redress** Arrangements) (**Wales**) **Regulations** 2013
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Resource implications relate to staff training in concerns management, claims and redress payments. Also staff resource to enable timely investigation
Link to Main Strategic Objective	To provide strong governance and assurance
Link to Main WBFG Act Objective	Provide high quality care as locally as possible wherever it is safe and sustainable

5. RECOMMENDATION

5.1 The Health Board is requested to: **DISCUSS** and **REVIEW** this report.