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Healthcare Inspectorate Wales

Governance Review

Aneurin Bevan University Health Board

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What we did 2

Summary 4

What we found 7

Quality and Safety Governance arrangements 7

Arrangements for identifying, capturing and analysing concerns and incidents 12

What is the learning from concerns and incidents? 222

What next 255

Appendix A – Quality and Patient Safety Assurance Reporting Structure….. 266

Appendix B – Improvement plan 268

What we did

Healthcare Inspectorate Wales (HIW) has a responsibility to provide the public with independent and objective assurance of the quality, safety and effectiveness of healthcare services, making recommendations to healthcare organisations to promote improvements.

As part of this responsibility, HIW needs to assure itself that NHS organisations have effective governance arrangements that promote safe and effective care. In order to do this, HIW has considered the effectiveness of Aneurin Bevan University Health Board's (ABUHB) arrangements for managing and learning from:

- Complaints/concerns from receipt to resolution;
- The reporting and management of incidents;
- Commissioned Reviews;
- Recommendations from External Bodies;
- Compliance with guidance and Welsh Government and Care Standards; and
- The role of the Quality and Patient Safety Committee in providing assurance regarding safeguarding and improving patient safety will also be considered.

The review also evaluated how ABUHB is using this information to address safety concerns and improve services.

HIW's methodology for the review consisted of:

- Document and data analysis;
- Analysis of a HIW issued self-assessment form and supporting documentation;
- Interviews with Independent Members and Executive Team Members, and interviews with staff groups (undertaken in February 2017);
- Discussions with the Aneurin Bevan Community Health Council;

- Observation of the Quality and Patient Safety Committee and the Audit Committee

The review team consisted of HIW Review Manager and a Peer Reviewer with extensive knowledge and expertise in relation to governance.

Summary

ABU HB was established on the 1 October 2009 and covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys. The health board serves an estimated population of over 639,000, approximately 21% of the total Welsh population.

The health board employs over 13,000 staff, two thirds of whom are involved in direct patient care.

Overall, we have found that ABUHB has been able to demonstrate effective governance and leadership in relation to the areas that we examined. Our review found that strong and effective leadership was being provided by senior and departmental staff within the health board. It was clear from our conversations with all levels of staff involved during the review that there was a strong commitment to learn from concerns and incidents, and to make improvements as appropriate. All staff approached the review very positively and were keen to receive constructive feedback to support their approach to maintaining high standards of care and continuous improvement.

We saw several examples of effective governance arrangements. The health board's governance structure in relation to patient safety is working well and is fit for purpose. The health board's Quality and Patient Safety Committee (QPSC), which has delegated responsibility for all matters relating to the quality of care the health board provide, appears to be functioning well, with clear governance structures and reporting lines. The Committee was well chaired; discussion was both challenging and supportive; and overall the agenda items discussed were appropriate and patient focused. We found that the QPSC is an example of good collective team work which evidenced challenge, scrutiny and professional rigor.

It is evident that the health board has systems and procedures in place to guide staff on how to manage concerns and incidents. The Putting Things Right Team has been established to oversee all concerns and incidents that are received by the health board. There is a good level of experience and expertise within the Putting Things Right Team, which is important as this team has a vital role in the management of concerns and incidents. Of the concluded concerns the review team viewed, it was noted that the letters were well written and the tone and quality was good yet sensitive to the subject matter.

Whilst overall we are pleased and encouraged with what we found, we also identified some areas which require further focus.

Although the health board has a well established Putting Things Right Team, timeliness of responding to concerns in line with *Putting Things Right*[1] is still proving challenging. This was usually as a result of delays during the investigation process and the complaints co-ordinators (who performance manage the investigation officers) being managed within the divisions and not by the Putting Things Right Team. However, the Putting Things Right Team have put in place mechanisms to try and improve the communication between them and the divisional complaint co-ordinators.

There appears to be an inconsistent approach when a Datix form is completed following an incident or concern as we were told some wards would complete the forms during their shift while others would wait until their shift had ended. We were told that this was because Datix could be time consuming to complete and if a member of staff was called away to care for a patient then the system would time out and they would then have to start the inputting process all over again. We also found that there could be delays in the vetting and validation of Datix forms following an incident due to the number of complaints co-ordinators

[1] The NHS in Wales follows the management of concerns process known as *Putting Things Right.* See: http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

varying between divisions. This inconsistency is concerning as it can cause delays in the validation of incident forms, therefore resulting in delays in the investigation commencing.

The health board also needs to continue the development of the Corporate Learning Committee to ensure that effective learning is spread throughout the health board. While the introduction of this committee is a positive development, we found that the committee needed to mature further. Specifically there needs to be further 'buy in' from divisions in order for this committee to become an effective, health board wide committee, demonstrating effective learning.

The recommendations made as a result of this review highlight the areas which require further improvement.

Overall our review has demonstrated an organisation that has effective leadership and has improved how it responds to and learns from concerns and incidents. ABUHB is an organisation that has engaged with its staff but still has challenges ahead in ensuring necessary improvements.

What we found

Quality and safety governance arrangements

Governance Structures

Each Local health board in Wales is governed by a Board of Executive Directors and Independent Non-Officer Members. This is set out in the local health boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. The Board[2] is responsible for the health board's overall system of governance and control, which includes robust risk management, and therefore must seek and be provided with assurance on the effectiveness of the systems and processes in place for meeting the health board's strategic objectives.

Each health board is required to establish a committee structure that it determines will best meet its own needs, taking account of any regulatory or Welsh Government requirements. The health board has established a range of committees, chaired by Independent Members of the Board, which have key roles in relation to the governance.

Each of the committee chairs submit an assurance report to each public meeting of the health board (every two months), which outlines key risks and highlights areas of development. Each committee also undertakes an annual assessment of effectiveness and produces an Annual Report for submission to the health board.

Quality, Safety and Patient Experience Functions

[2] See details and Board membership: http://www.wales.nhs.uk/sitesplus/866/page/40442

The health board's governance structure in relation to patient safety is as follows. Each division has a Quality and Patient Safety Forum (six in total) and these feed into the health board's Corporate Learning Committee. Escalation from this committee is fed up to the Quality and Patient Safety Operational Group, then through to the Quality and Patient Safety Committee and then finally to the Board. Please see Appendix B for the Quality and Patient Safety Assurance Reporting Structure.

It appears the current governance structure is working well, with each committee and sub-committee having clear reporting lines to the Board. It was evident that the committees, in relation to patient safety, were performing important functions and were fit for purpose. Of these committees and sub-committees, there is representation from appropriate individuals and independent members. As part of our review, we observed a selection of committees to witness the quality of discussion and level of scrutiny. Further details of this can be found later in the report.

Quality, Patient Experience and Safety Committee

The health board's Quality and Patient Safety Committee is the key mechanism for providing assurance to the Board regarding the quality and safety of its services. The committee also keeps under review the health board's risks in relation to patient safety and the quality of care. The committee is made up of and chaired by only Independent Members. Executive Members are in attendance with standing invitations to other bodies such as the CHC and HIW. The committee meets five times a year.

As part of the review, we observed one of the health board's quarterly QPSC meetings which is held in public but does hold a closed session that takes place before the public committee. We felt that the committee's agenda was appropriate to the role of QPSC within the health board.

The Managers and Clinicians who were presenting papers to the committee were knowledgeable and experienced in their field of practice. It was clear that they were not afraid to give balanced presentations highlighting issues where improvements were needed and the mechanisms available for making such

improvements. They were also encouraged by the Chair to provide challenge where they thought the health board needed to take action at Board Level.

Patients were central to all the discussions that took place at the committee and the Executive and Independent Members who were present at the committee played an important role in achieving this.

There was impressive professional rigor and challenge of the presenters on the items being discussed. This was very evident from the Independent Board Members and the Community Health Council Representative on the committee. The environment was one of professional support where everyone's views were seen as important and were listened too. The review team were impressed by the input and support given at the committee by the Executive Medical Director.

The QPSC agenda was quite lengthy for the time allocation. Consequently, the last few items were rushed. However, the Chair took on board this issue and agreed to the suggestion that these outstanding items be the agenda's first items at the next QPSC meeting, so that there would be sufficient discussion of all agenda items. Consideration should be given to the length of time allocated to each agenda item to ensure that there is sufficient discussion of every agenda item.

Recommendation 1:

The health board should ensure that sufficient time is allocated to each agenda item on the Quality and Patient Safety Committee agenda

There was clear evidence that where actions were required that they were agreed and duly recorded. It was particularly noteworthy that staff were encouraged to raise any issues throughout the meeting. Independent Members were also able to challenge in a positive manner. It is our view that the health board's QPSC is vibrant and fit for purpose and it was an example of good collective team work under the control of an experienced Chair.

One example we saw of issues being correctly escalated, was in relation to a report of quality and patient safety issues across the Caerphilly district area to

the Unscheduled Care Quality and Patient Safety Forum. This report highlighted clear trends, themes or clusters which required escalation to the Quality and Patient Safety Forum for consideration.

Audit Committee

We also observed the Audit Committee. The Audit Committee is responsible for reviewing the system of governance and assurance. It also keeps under review:

- the risk approach of the organisation and utilises information gathered from the work of the Board,
- the work of other Committees and
- other activity in the organisation in order to advise the Board regarding its conclusions in relation to the effectiveness of the system of governance and control.

We found that there was clear evidence that the Committee's agenda was very appropriate to the role of Audit Committee within the health board.

Putting Things Right

In relation to concerns handling, the health board should adhere to the Putting Things Right[3] guidance which was produced for the NHS in Wales. It enables responsible bodies to effectively handle concerns according to the requirements set out in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations ("the Regulations")[4].

Putting Things Right guidance applies to all health boards, NHS Trusts in Wales, independent providers in Wales providing NHS funded care and primary care practitioners in Wales.

[3] See: http://www.wales.nhs.uk/governance-emanual/putting-things-right

[4] See: http://www.legislation.gov.uk/wsi/2011/704/contents/made

The *Putting Things Right* guidance[5], states that concerns are: "…*issues identified from patient safety incidents, complaints and, in respect of Welsh NHS bodies, claims about services provided by a Responsible Body in Wales*".

Serious Adverse Incidents

A significant incident is defined as any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded healthcare, or significant harm to an employee or contractor working for ABU HB.

Significant incidents are potentially reportable[6] to Welsh Government as Serious Adverse Incidents (SAIs).[7] The classification of a serious patient related adverse incident, using a list supplied by Welsh Government.

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[5] See: http://www.wales.nhs.uk/sitesplus/documents/861/Healthcare%20Quality%20-%20Guidance%20-%20Dealing%20with%20concerns%20about%20the%20NHS%20-%20Version%203%20-%20CLEAN%20VERSION%20%20-%2020140122.pdf

[6] In conjunction with *Putting Things Right* Guidance on dealing with concerns about the NHS…Serious Adverse Incidents that occur anywhere within the Welsh Ambulance Services NHS Trust must be reported whenever possible within 24 hours of the occurrence to Welsh Government using the relevant form to improvingpatientsafety@wales.gsi.gov.uk

[7] See: http://www.wales.nhs.uk/sitesplus/documents/1064/Handling%20Serious%20Incidents%20Guidance1.pdf

Arrangements for identifying, capturing and analysing concerns and incidents

Concerns

The health board receives and identifies concerns in multiple forms:

- Email, post, phone or in person
- Formal complaints which are dealt with under the *Putting Things Right* process
- On the spot concerns which are normally dealt with immediately and informally
- Claims

The health board has a procedure[8] in place to guide staff on how concerns that are received as complaints should be investigated and responded to in order to deliver effective conclusions. This procedure should be used in conjunction with the health board's *Putting Things Right* Policy and Welsh Government's *Putting Things Right* – Guidance on Dealing with Concerns about the NHS.

All concerns received by the health board, whether formal[9] or informal[10] are recorded on the Datix[11] system. Concerns are recorded centrally by the Putting Things Right Team which enables the health board to monitor and identify any themes or trends from all concerns received. We were informed that all formal concerns which are received by the health board are managed by this team. The Putting Things Right Team is managed on a day to day basis by the

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[8] *Putting Things Right*- Procedure on the Management of concerns raised by patients and their representatives (complaints)

[9] Formal- these concerns are dealt with under the *Putting Things Right* regulations.

[10] Informal- not usually dealt with under the *Putting Things Right* regulations and are concerns that can be dealt with up to 48 hours after a concern has been raised. These concerns are usually dealt with 'on the spot' or in a short period of time.

[11] Datix provides web and patient safety software for healthcare risk management. Delivering safety, risk and governance solutions through a process of continuous operational improvement

Assistant Director of Organisational Learning, who has responsibility for '*Putting Things Right'*. At the time of the review, the Executive Medical Director had overall accountability for this team. However, the responsibility has recently transferred to the Director of Nursing's structure, which better links with the Patient Experience, Safeguarding and Health Care Standards lead responsibilities.

All formal concerns are graded on receipt by the Putting Things Right Team. The grading system is completed in terms of severity, from 1 (no harm) to 5 (catastrophic harm). This grading system is in accordance with the All Wales grading for serious incidents. Concerns graded as a 4 or 5 are also reported to Welsh Government as a Serious Adverse Incident (SAI). The health board has a separate process for investigating these incidents. Further details can be found later in the report.

The Putting Things Right Team disseminates the concern to the complaints co-ordinators within the appropriate division so that an investigation officer with the appropriate skills and knowledge can be appointed. Each division has complaints co-ordinators who are responsible for performance managing each complaint within their division. All the investigation officers at divisional level have received appropriate Root Cause Analysis[12] training to carry out this role and we were told that this training was undertaken before they commenced any investigations. However, we learnt that the number of complaints co-ordinators at divisional level varies between each division. These posts do not sit within the Putting Things Right Team; instead they are managed within the divisions. This can at times be challenging for the Putting Things Right Team as they have no accountability or management responsibility for the complaints co-ordinators. This can lead to difficulties in trying to meet target dates to adhere to the *Putting Things Right* process. We were told that the Putting Things Right Team has established regular meetings with all the complaints co-ordinators to

[12] See: http://www.nrls.npsa.nhs.uk/rca/

try and overcome this and improve working relationships. However, it is still at times proving challenging to met the target dates due to divisions relying on the Putting Things Right Team to performance manage the investigation process, due to pressure with their own work commitments.

We visited Ysbyty Ystrad Fawr Hospital in Ystrad Mynach, in order to understand how effectively concerns are being dealt with at ward-level. We were told that it was normal practice for band 7 sisters/ charge nurses and band 6 deputy sisters/ deputy charge nurses to undertake the investigation of a concern. We were told that following the receipt of a concern by the Putting Things Right Team, it would then be disseminated to the appropriate division. The complaints co-ordinator would appoint a trained investigation officer to complete the investigation on other wards and departments, therefore remaining independent and objective. This was noted as good practice. Investigation officers would liaise with the appropriate healthcare professionals that are involved in the concern or incident in order to gather a comprehensive timeline into the events that led to the concern or incident. We were also told that consideration was being given to experienced band 5 nurses at Ysbyty Ystrad Fawr undertaking the training to become investigating officers in the future in order to increase capacity.

Timeliness of dealing with concerns

During 2015/2016, the health board received 1008 formal complaints and 939 informal complaints. Under *Putting Things Right*, complainants, in most cases, should expect to receive a formal reply to their concerns within 30 days of them raising their concern. Where this can not be met, reasons should be formally provided to the complainant and a date on when they can expect the formal reply provided. For formal complaints, the health board's complaints performance for 2015/2016 against the 30 day target was 59%. Of the 1008 formal complaints, only 858 were acknowledged in two days. It is clear that there is scope for improvement in this area, and the health board recognises that improvements need to be made in relation to meeting these targets.

Despite the *Putting Things Right* guidance, we identified issues with the processing of concerns in a timely manner. For example, the acknowledgment letters and the 30 day target for completing an investigation were not always met.

We were told that some of these delays related to the fact that investigations take place at divisional level. Although we agree that it is appropriate for the investigation to take place at divisional level, we found that as the Putting Things Right Team has no accountability or management responsibility for the complaints co-ordinators or the investigating officers at divisional level, it can be difficult to ensure timely investigations are undertaken.

We learnt from the investigating officers that some of the delays at divisional level related to external factors beyond their control such as obtaining further pertinent information from external agencies or from the complainant directly. However, undertaking investigations alongside their own work commitments also prevented them from completing investigations within the specified timeframe. We were told that the investigations officers did not have any issues in engaging with staff in terms of gaining their contribution to the investigation.

Recommendation 2:

The health board should consider giving protected time to investigation officers in order ensure that the 30 day target is met wherever possible.

We also saw evidence that the Putting Things Right Team are working at the maximum of their capacity due to staff shortages. The Assistant Director of Organisational Learning is currently covering these shortages directly. There is also an over-reliance on the Putting Things Right Team to deliver operationally when it comes to the investigation of concerns or incidents, for example, ensuring that targets dates are adhered to when this should be performance managed and the responsibility of each division's complaints co-ordinator.

Recommendation 3:

The Putting Things Right Team should maintain an overview of trends, themes and clusters that can then be escalated to the appropriate committee and serious concerns should be dealt with and investigated by staff within the divisions.

Recommendation 4:

The health board should ensure that it operates in line with its *Putting Things Right* policy[13] which clearly sets out individuals' responsibilities.

All formal responses to concerns are submitted by the division to the Putting Things Right Team for a quality check, and are signed off by the Chief Executive before release. We were told that this was necessary to ensure the Chief Executive remained up to date with the concerns being dealt with by the health board. We note this as good practice. The health board also has a designated Independent Member who acts as a Patient Champion and links in with the Putting Things Right Team. The Patient Champion, along with the Chair of the health board, will also review responses to assist in responding to complainants ongoing concerns when they are not satisfied with the initial response to their complaint.

We were told that the majority of complaints raised at ward level were treated as informal complaints and were dealt with quickly and efficiently by the ward staff. Informal complaints, which are normally dealt with 'on the spot' are usually managed at divisional or ward level and not through the *Putting Things Right* process. Informal complaints should be dealt with within 2-5 days and are normally dealt with verbally or via email correspondence. Concerns graded 1 are normally dealt with informally, if this is acceptable to the complainant. This

[13] The management of Concerns (complaints, Claims and Patient Safety Incidents)

is a good way to deal with concerns as this usually means an early resolution for the complainant.

We asked the health board to provide a sample of 5 concerns from receipt to resolution in order to assess the effectiveness and quality of the process from the past 12 months. The sample included one concern from each category (graded 1-5), one which was resolved within the target date and one that fell outside the target. We found that appropriate documentation is being completed and complainants are being informed when target dates are being missed, and most importantly the reasons why are being explained to them. The final response letters (which are viewed and signed off by the Chief Executive) for all the concerns we reviewed were clear, comprehensive and gave the complainant the opportunity to discuss the content of the letter with the health board. The letter also provided the complainants with additional information if they still remained unsatisfied with the outcome, signposting towards the Public Services Ombudsman for Wales. It was evident from the sample we examined that complainants were treated with respect and courtesy.

During 2015/2016 a total of 103 concern cases were referred to the Public Ombudsman for Wales (PSOW). This is a slight decrease from the previous financial year. Of the 103 cases, 25 were upheld.

Concerns are reported to the health board's Quality and Patient Safety Committee on a bi-monthly basis by means of a concerns report. This report includes the number and nature of serious concerns received as well as a summary of the learning and the actions taken. This is to provide the Committee with assurance that concerns are being appropriately managed.

Redress Panel

The health board is required to consider whether a concern reflects a breach in their duty of care and has established a Redress Panel to assist with this process. If a breach of duty has been identified then consideration needs to be given as to whether the breach of duty caused the patient any harm, which

would then mean there is a qualifying liability and redress needs to be considered. Redress can mean:

- An apology
- Remedial action
- Compensation.

The health board was the first in Wales to establish a panel of this kind and in doing so was held up as an example of good practice across Wales. During 2015/2016, the health board had 49 cases that were heard by the Redress Panel. Of these 49, 33 cases were found to have qualified liability established. Within the Putting Things Right Team, there is a dedicated legal team which contribute to all Redress cases which ensured that all Redress cases had the appropriate level of consideration.

Incidents

During 2015/ 2016, the total number of patient related incidents reported via Datix was 14,006. The majority of these incidents (4299) were categorised as 'Slips, trips, falls and collapse (including patient found on floor)'.

The health board uses the Datix system for the recording of incidents, which also includes the recording of near misses[14] and Never Events[15]. All staff are able to access the Datix system to record these. However, we found that not all staff have been trained to use the system. Whilst general Datix training is covered as a topic by the induction process for all staff, and the health board has a framework and toolkit to guide staff about what to report, the more specific training on the use of Datix is provided by the Datix administrators.

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[14] A near miss is an unplanned event that threatens human safety or health, the environment, or the continued normal operation of the business enterprise, wherein the last protective barrier is challenged, but defeated.

[15] Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

These administrators provide training to the ward manager who should then cascade that training to their staff.

Once recorded on the system, each division has dedicated individuals (Patient Safety Leads) who vet and validate the Datix forms. This is to ensure that the forms are completed appropriately. However, the number of these individuals for each division varies. For example, we were told that the unscheduled care division (the largest division) only has one complaints co-ordinator who can vet and validate incidents, whereas the families and therapies division has five. This inconsistency can cause delays in the validation of incident forms, therefore resulting in delays in the investigation commencing.

Recommendation 5:
The health board should review the number of Patient Safety Leads within each division to ensure equity.

Once vetted, all Grade 4 and 5 incidents are submitted to the Putting Things Right Team. The Putting Things Right Team meets with the relevant division within the first week following the incident to establish what happened and agree if further information or an investigation is required. If an investigation needs to take place, then terms of reference are devised for the investigation process by the serious incident review team, which is convened following every Grade 4 or 5 incident. Membership of the team is included in the health board's 'Management of Serious Concerns (Level of Patient Harm Graded Severe or Catastrophic)' Policy and Procedure.

All SAI's (graded 4 or 5) and Never Events are also reported in line with Welsh Government requirements. Where incidents are reported to Welsh Government, the health board has a 60 working day target for the completion of an investigation. The health board should then provide Welsh Government with a closure form providing assurance on the findings of the investigation, the learning and any subsequent actions taken. The health board acknowledges that the 60 day target has proved challenging to meet, and as such, appointed a Serious Concerns Assurance Officer in June 2016. The number of SAI's

reported to Welsh Government for 2015/2016 was 139, an increase from 2014/2015. This was primarily due to the health board reporting all in-patient falls that resulted in a fracture to a long bone and all healthcare associated pressure ulcers (grade 3 or above) whether avoidable or unavoidable. The health board did not previously report these as SAI's. .

In 2015/2016 the health board reported three Never Events to Welsh Government. These were a misplaced nasogastric tube, retained swab and wrong implant. The process of investigation of Never Events is in line with the serious incident process, with the exception that the NHS Wales' Delivery Unit provides scrutiny of the investigation process. This scrutiny is aimed at ensuring that the investigation is thorough, that there is learning as a result of the incident and that improvement action is taken as necessary.

The Datix system allows the health board to run reports in order to identify themes and trends; these are considered via the health board's Quality and Patient Safety Operational Group. These reports can be generated at either corporate level, divisional level or within teams. An example of when this was used in practice was provided to the review team. The health board had identified that there had been a rise in the number of patients suffering fractures following falls, so the health board has focused on in-patient falls by establishing a falls scrutiny panel. Staff we spoke with at Ysbyty Ystrad Fawr told us that the hospital layout has impacted on the number of patient falls there due to the wards being single patient rooms, and therefore observation of patients is limited. Staff told us that they were able to feed this information via Datix and that this was identified as a theme that emerged via the governance processes with action now being taken.

It was suggested to us that some staff groups were hesitant to input information onto Datix and instead preferred to discuss a concern or incident with their senior colleagues for them to deal with appropriately. Although we acknowledge that discussion between senior colleagues is good practice, it is still the responsibility of the individual who is raising the concern or incident to input onto Datix to ensure that patient safety is monitored and patient safety is

ultimately reduced. The Putting Things Right Team has developed good working relationships with the clinical leads for each division which has aided the ability of the health board to act quickly in response to incidents. An example was provided where a clinical lead in A&E had immediately highlighted a serious incident to the Putting Things Right Team which meant the Putting Things Right Team could act on it straightaway. This is an example of good practice.

During our visit to Ysbyty Ystrad Fawr, staff indicated that it was sometimes time consuming to complete Datix. There have been some improvements and the system now uses drop down boxes which is more efficient and user friendly for staff to use. However, there appears to be varied approaches to when Datix is completed following an incident. For example, we found that that one ward usually completed Datix at the end of a shift rather than immediately following the incident. The rationale behind this was because if that member of staff was called away to care for a patient then the system would time out and they would then have to start the inputting process all over again. However, another ward completes Datix within the working hours and because of the frequent use of Datix they have been able to refine what needed to be placed on Datix. It is vital that the health board ensures that staff are made aware of the importance of completing a Datix as soon as reasonably practicable as the information is more likely to be accurate.

Recommendation 6:
The health board should review its Datix training programme to ensure the curriculum is comprehensive and meets the needs of the users to ensure accurate and timely recording of incident and concerns.

Recommendation 7:

The health board should ensure that all staff are reminded of the need to record concerns and incidents on Datix.

What is the learning from concerns and incidents?

The health board has a procedure[16] in place that provides clarity to staff about the processes in place to learn from concerns and incidents. This procedure describes how concerns are managed within the divisions. The Policy explains that divisions should be using adverse events as learning opportunities to improve patient safety. In order to do this, the health board has set up divisional Quality and Patient Safety forums. Part of the remit of these forums is to review incidents, complaints and Ombudsman investigations. Each of these forums review trends across their division, review and monitor action plans, ensure actions are implemented and disseminate any good practice across the division. Any concerns or issues found that would affect the whole organisation would be escalated to the Corporate Learning Committee.

The Corporate Learning Committee is responsible for ensuring that themes are identified from incidents, complaints and claims. It is also responsible for ensuring that appropriate learning is identified, with actions put in place and implemented to improve patient safety and the quality of patient care. Outcomes from audits and external reviews are also discussed. Concerns identified by the health board's six Quality and Patient Safety forums, are escalated to this committee. The committee also has the responsibility for the sign off of the actions to be taken of serious patient safety incidents graded 4 or 5 as well as Ombudsman investigations.

The committee is chaired by the Assistant Director of Organisation Learning and has representation from each division, as well as members from the Executive team and the Putting Things Right Team. It is noteworthy that three directors are also involved in this committee (the Director of Nursing, the Medical Director and the Director of Therapies and Health Science). While the introduction of this committee is a positive development, discussions with staff

[16] Health Board Policy Document: *Putting Things Right*- Learning from Concerns

suggested that it needed to mature further. Specifically there needs to be further ‘buy in’ from divisions in order for this committee to become an effective, health board wide committee, demonstrating effective learning. For example, we were told that the number of representatives from Unscheduled Care can vary or at times have no representatives attend due to the very nature of the division and it being the largest division across the health board. This is concerning, as for effective learning to take place, the health board should have a consistent approach across all divisions, ensuring that each division is aware of their responsibility to participate in such meetings.

Following every Learning Committee, the Putting Things Right Team generates learning bulletins that are circulated to all divisions to be cascaded to all staff. They can also be found on the health board’s intranet. We reviewed these bulletins and believe their introduction is good practice and that they highlight the key areas that staff need to be aware of in relation to learning and applying the learning

To understand more about the effectiveness of the health board in sharing learning relating to concerns, we engaged with the Community Health Council (CHC). Whilst the CHC has a positive relationship with the health board, the only comment to note was that from their experience, actions and outcomes / learning are not always filtered down to divisional or ward level. The responsibility to ensure the relevant information was filtered down to ward level regarding the appropriate actions is left with each division. We were told that the relationship between clinicians and the Putting Things Right Team has improved, and as a result there is a belief that learning has improved as a consequence.

Our visit to Ysbyty Ystrad Fawr found that there were appropriate arrangements in place to support the learning agenda. For example, at Ysbyty Ystrad Fawr there are regular meetings where the senior nurse, ward sisters and the divisional nurse attend. At this meeting they discuss any relevant complaints, concerns or incidents where any lessons learnt or actions would need to be disseminated throughout the division. We were also told that at the conclusion

of any investigation the investigating officer at Ysbyty Ystrad Fawr would always give feedback to the relevant ward sister regarding the findings and any actions or learning points that needed to be actioned within the ward environment. A realistic timeframe would then be agreed for any actions to be undertaken and that if there were any outstanding actions or concerns then this would be escalated to the senior nurse.

The latest review by the Welsh Risk Pool, which looked at the implementation of the *Putting Things Right,* identified that ABUHB has made progress from the previous year and that it has a strong framework for learning from concerns. We found during our review that the health board has the mechanisms in place for effective learning, however as outlined earlier, further buy in from the divisions needs to be secured in order for learning to become effective across the whole health board.

Recommendation 8:
The health board should ensure that the divisions are committed to full participation within the Corporate Learning Committee

5. What next

This review has resulted in the need for the health board to complete an improvement plan (Appendix B) to address the key findings from the review. The improvement plan should:

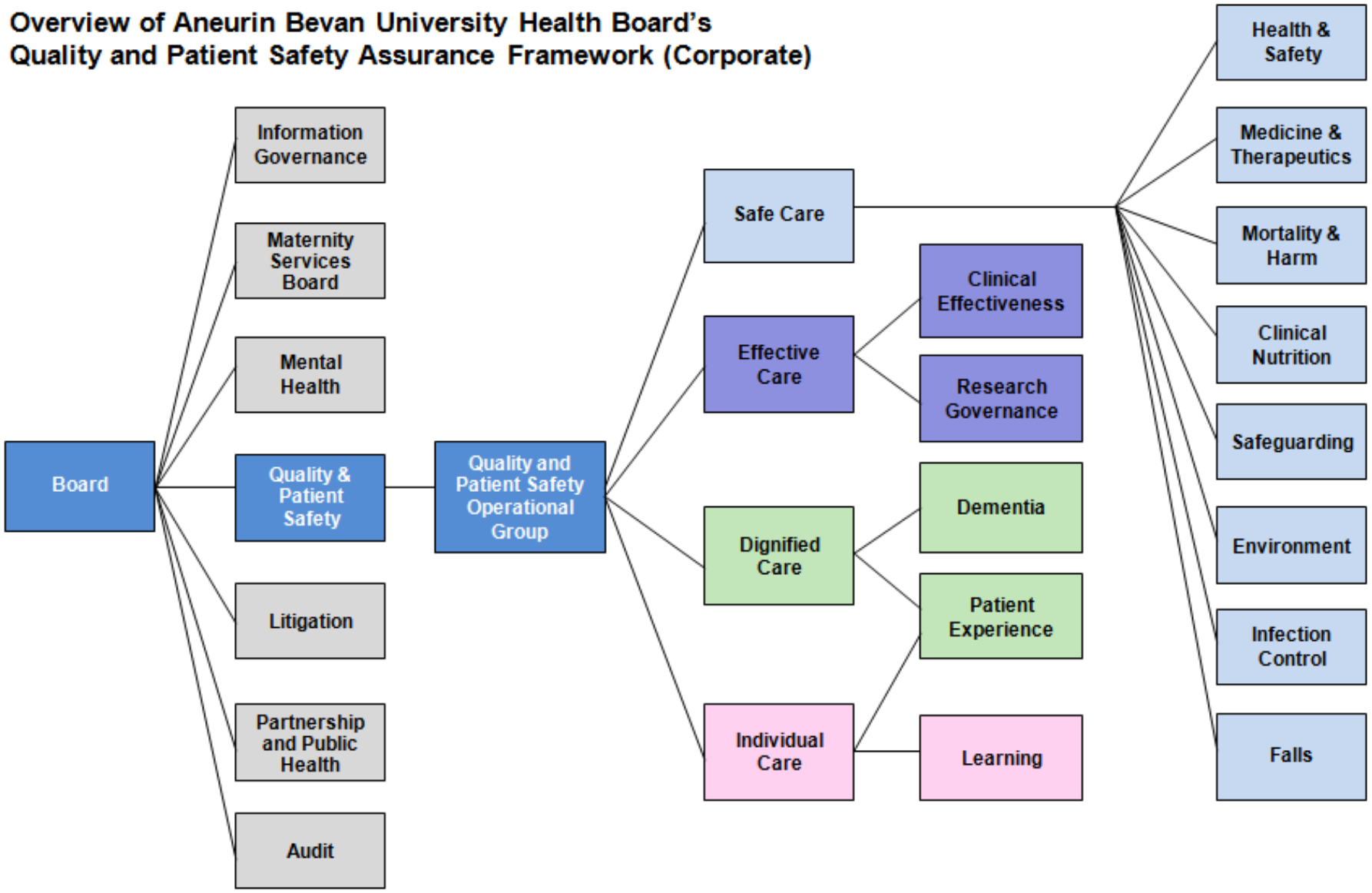
- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measureable, achievable, realistic and timed
- Include enough detail to provide HIW with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this review the health board should:

- Ensure that findings are not systemic across other departments/units within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The health board's improvement plan, once agreed, will be published on HIW's website.

Overview of Aneurin Bevan University Health Board's Quality and Patient Safety Assurance Framework (Corporate)



Appendix B – Improvement plan

Governance Review: Improvement Plan

Health Board: Aneurin Bevan University Health Board

Page Number	Improvement needed	Health Board Action	Responsible Officer	Timescale
9	1. The health board should ensure that sufficient time is allocated to each agenda item on the Quality and Patient Safety Committee agenda			
15	2. The health board should consider giving protected time to investigation officers in order ensure that the 30 day target is met wherever possible			

16	**3. The Putting Things Right Team should maintain an overview of trends, themes and clusters that can then be escalated to the appropriate committee and serious concerns should be dealt with and investigated by staff within the divisions**			
16	**4. The health board should ensure that it operates in line with its *Putting Things Right* policy[17] which clearly sets out individuals' responsibilities**			
19	**5. The health board should review the number of Patient Safety Leads within each division to ensure equity.**			

[17] The management of Concerns (complaints, Claims and Patient Safety Incidents)

21	**6. The health board should review it Datix training programme to ensure the curriculum is comprehensive and meets the needs of the users to ensure accurate and timely recoding of incident and concerns**			
21	**7. The health board should ensure that all staff are reminded of the need to record concerns and incidents on Datix.**			
24	**8. The health board should ensure that the divisions are committed to full participation within the Corporate Learning Committee**			

Health Board Representative:

Name (print): .....

Title: .....

Date: .....