Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust

NHS WALES GIG CYMRU

Learning and Putting Things Right Concerns Annual Report 2013/14

Contents

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Foreword

I am pleased to introduce this, our third Welsh Ambulance Services NHS Trust Concerns Annual Report since the introduction of the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

Our strategic intent over the last year has been to improve and simplify access for the citizens of Wales to ensure anyone can contact us easily to raise their concerns about any aspects of the services we provide and equally to be able to provide thanks which we then pass to our staff.

When a person raises a concern with us, it shows us that they want to be involved in working with us to improve our services. This input is so important in enabling us to develop our organisation so that we can continue to provide effective services and care to patients at a time when they need us.

As Chief Executive of the Welsh Ambulance Service, I am privileged to be able to provide the leadership to the teams of hard working staff managing and investigating concerns and to the managers learning from concerns. It is important for me to understand the concerns that our service users have and to see where we have made a significant positive difference to someone with the services we provide.

The Trust recognises that concerns are an integral element of improving the patient's overall experience of health care and help to assure safe, high quality care.

Last year was one of our busiest yet and we successfully resolved more concerns for individuals either through formal investigation or via on the spot resolution where complainants have the opportunity to speak directly to a manager within the Trust. This has provided us with a wealth of information on what service users need and expect from us.

We recognise there is more to do and throughout this report you can read how our future plans are taking shape. Moving forward, we want to deliver more timely responses to concerns, raise our profile further to make it easier for people to raise a concern, ensure we maintain regular contact and share more of the learning from our concerns. The trends that we identify and lessons to be learned play a key role in enabling us to improve the quality of services and care received by our patients. Providing quality NHS services for citizens of Wales is a priority for the Trust.

Elwyn Price-Morris
Chief Executive

Introduction

This annual report is aimed at providing assurance to patients and their families, the public and our stakeholders that the Trust is dealing with concerns effectively by investigating once and investigating well in accordance with the Regulations. The report shows how we have learned from concerns this year and what we are doing to increase our learning to improve services in the coming year.

In 2013/14 the Trust has received 1133 complaints (including on the spot concerns) from patients and members of the public, 81 claims and 1602 incidents reported by our staff. In terms of formal complaints, this year our numbers have remained consistent at 506 received this year, in comparison to 498 received last year.

The Trust has continued to improve access for people to raise their concerns with us. We continue to increase our telephone contact with patients and their families to provide them with an opportunity to discuss their concerns with Trust managers. The Trust assigns an individual member of staff as a point of contact whilst the concern is being investigated. The number of 'on the spot concerns' that we have dealt with this year has increased by over 50% to 627 cases as a consequence of working closely with Trust managers to develop the Trust's ability to manage concerns in this positive way.

In comparison with the 2012/13 annual report, incidents reported by staff have reduced by 324 incidents and the number of new claims received by the Trust has increased slightly to 81.

Concerns

In accordance with Putting Things Right, concerns include any complaint, claim or reported patient safety incident (about NHS treatment or services) to be handled under the arrangements.

Complaint:
raised when a patient, relative or member of the public contacts the Trust to raise concerns;

Patient Safety Incident:
raised by Trust staff when something has gone wrong with service, care or treatment;

Claim:
raised when a patient, member of the public or third party is claiming financial compensation from the Trust i.e. for clinical negligence or a road traffic collision involving a Trust vehicle.

Our Goals

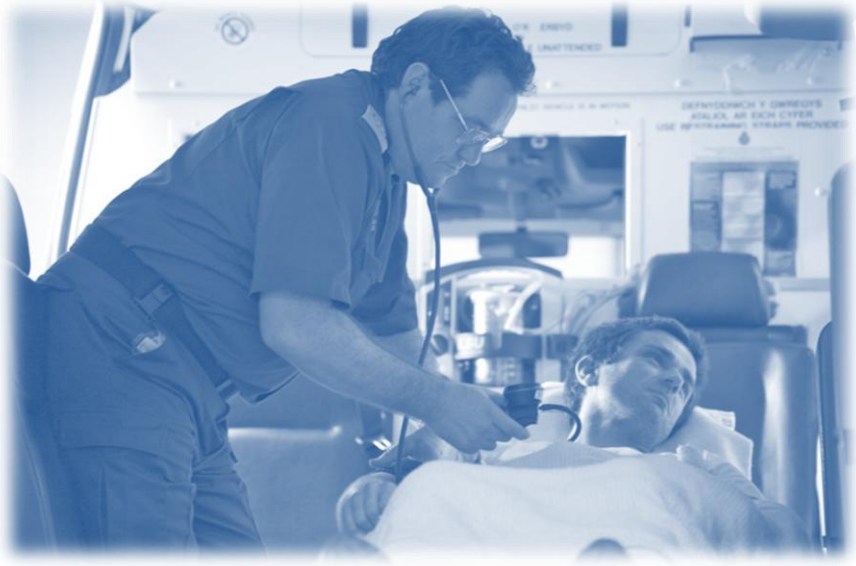
The Trust recognises the value in the effective management of concerns and the subsequent organisational learning that support the improvement of patient safety and development of services.

Through the effective management of concerns, the Trust aims to:

- Involve the person raising a concern to ensure that they are part of the process and fully understand the Trust's response and outcome of the investigation into the concerns that they have raised;
- Apply common principles to the management of concerns raised regarding services provided by the organisation;
- Establish a consistent model for dealing with concerns within the organisation and jointly with other partner organisations;
- Apply common data collection procedures to enable the identification of trends and themes emerging from concerns;
- Establish consistent methods for learning from concerns;
- Establish a means through the Organisational Learning Group to identify and disseminate good practice and learning throughout the organisation.
- To establish clear lines of communication and provide regular contact with the person raising a concern.

In March 2014, the Trust has adopted a Putting Things Right Policy for the organisation. This supports the Trust's core values that are applied to the handling of concerns. These values are:

- To act with integrity and honesty;
- To treat everyone with dignity and respect;
- To put our patients at the heart of everything that we do;
- To encourage learning, innovation and new ways of working;
- To remove waste, variation and harm.



Organisational Arrangements

During 2013/14 the Trust has established its Putting Things Right Team and embedded policy and processes for the handling of concerns into the culture of the organisation.

The Trust has renamed its Concerns Team to become the 'Putting Things Right Team' to promote the awareness of the Putting Things Right Guidelines with both staff and the public.

The Trust's Chief Executive continues to provide a high level of support to the concerns process, chairing the Concerns Monitoring Group, reviewing each formal complaint investigation and by writing to complainants personally, where they have formally raised a concern.

At Executive level, responsibility for concerns remains with the Executive Director of Medical & Clinical Services supported by a Non-Executive Director as Trust Board Champion for concerns. The day to day responsibility for concerns remains with the Head of Business Management & Concerns.

In 2013/14, the Trust has replaced the role of Putting Things Right Facilitator with a National Manager for Concerns and Service Improvement. This role is to embed concerns policies and processes into the organisation and to provide assurance that they are working effectively to maintain a high standard of quality, performance and learning from the Trust's handling of concerns.

The Trust has appointed Investigation Supervising Officers to provide a single point of contact for people raising concerns and to ensure that investigations are done once and done well. All concerns are received centrally to be acknowledged and closed.

The Trust continues to monitor concerns within the Concerns Monitoring Group, held monthly and chaired by the Chief Executive. This group provides assurance of concerns handling to the Quality Delivery Committee of the Trust Board.

Decisions regarding redress are managed by the Trust's Redress Panel. The Redress Panel considers cases where the investigation has determined that a breach of duty of care has occurred or where an allegation of harm has been made against the Trust and there may be qualifying liability.

Additional quality assurance measures are in place with Patient Safety Managers, Clinical Support Officers, independent expert advice, legal experts and patient advocates providing support to concerns investigators and people raising concerns where a case is being handled through the redress process.

Achievements 2013/14

In 2013/14 our achievements include:

1. **Putting Things Right Team** - The Trust has developed its Concerns Team to become the Putting Things Right Team with new roles of Investigation Supervising Officers, Concerns Administrators and a National Manager for Concerns and Service Improvement. These roles have enabled an increase in access for people to raise concerns and have improved the co-ordination and quality of investigations. The team are working consistently and effectively as a national team whilst being based in localities across Wales, which provides local knowledge and opportunity to meet with the public.

2. **Embedding Putting Things Right Principles** – The Trust has developed its new concerns management processes into policy with patient focused principles from Putting Things Right that are being embedded into the organisation. The Trust has introduced an Organisational Learning Policy and a Putting Things Right Policy which are being implemented across the organisation.

3. **Organisational Learning Group** – Following the creation of a Learning Policy, the Trust has established a new Organisational Learning Group led by the Medical Directorate. The group members represent all areas of the Trust with a purpose to ensure that the Trust is a learning organisation that pursues continuous improvement to patient safety, staff safety and service user experience.

4. **Increasing Access to Raise Concerns** – By increasing the awareness and access to raise concerns, the Trust has received an increase in the number of 'On the Spot' concerns by a significant 50% this year. Concerns dealt with on the spot are a valuable source of information regarding service user experience and provide the opportunity for people raising a concern to speak directly with a Trust Manager to discuss and address their concerns at the time they are raised.

5. **Reduction in Re-opened Cases** – In 2012/13 the Trust recorded 69 requests for cases to be re-opened which equated to 8% of concerns. Following several recommendations, this year, we have reduced this to 46 cases which equates to 4% of concerns. This is a significant improvement which can be used as a quality indicator in terms of the satisfaction of the person raising the concern with the Trust's response and handling of the concerns that they have raised.

6. **Concerns Monitoring & Assurance** – The Trust has reviewed and implemented a new governance structure in January 2014. Monitoring of concerns will continue to be reported to the Concerns Monitoring Group chaired by the Chief Executive and monitoring of organisational learning from concerns will be co-ordinated by the Organisational Learning Group chaired by the Assistant Medical Director. Both of these groups report to the newly formed Quality Delivery Committee of the Trust Board which is chaired by a Non-Executive Director independent member.

Letter sent in from a patient:

We would like to say you must be very proud to be in charge of such an admirable team of professionals.

Thank you

Concerns Statistics

Performance

NHS organisations in Wales are required to report on performance of concern acknowledgement and response times.

During 2013/14, the Trust acknowledged 81% of complaints within the 2 working days target set by Welsh Government.

The target for concerns dealt with under Regulation 24, where there has been no significant harm caused, is to have a final response to the person raising the concern within 30 working days. In 2013/14, the Trust achieved a performance of 30%.

A response within 30 working days is not always possible, for example if a concern is complex and contains allegations which require investigation by the Local Authority prior to the commencement of an investigation under the Regulations. In these cases, the concerns team have endeavoured to ensure that the person raising the concern is kept informed of the progress of their concern investigation.

For a concern case to be considered under the redress process of the National Health Service (Concerns, Complaints and redress Arrangements) (Wales) Regulations 2011, there must be evidence of a qualifying liability in tort.

Qualifying liability in tort is where a Welsh NHS body has both (1) failed in its duty of care to a patient, and that 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 payment of compensation under the regulations should be considered.

This year, fifty four complaint cases were considered for redress following their initial investigation and twelve complaint cases were re-opened and considered for redress following a final response.

Within the time frame, twenty three cases have been closed during the last financial year of which only 2 cases were found to have a qualifying liability and were Regulation 26 cases. Half of these cases received a final response within 6 months (Table 9).

Re-opened cases happen where the person raising the concern is not satisfied or has further queries with the final response from the Trust. In 2013/14 the Trust has improved the quality of concern investigations and reduced the number of these cases to 4%

Table 1: Concerns Received by Function

Service Area	Complaints	Joint Complaints	Incidents	Claims
	inc On the Spot Concerns	with Health Boards		Clin neg & personal injury
EMS Control Centres*	169	22	138	3
PCS Control Centres*	115	0	7	0
Emergency Services	294	46	1053	52
Patient Care Services	393	14	194	14
NHS Direct Wales	67	1	159	4
Other	12	0	51	8
TOTAL	**1050**	**83**	**1602**	**81**

*EMS Emergency Medical Services / PCS Patient Care Services

Table 2: Concerns by Area

Service Area	Complaints	Joint Complaints	Incidents	Claims*
	inc On the Spot Concerns	with Health Boards		
North Wales: (Betsi Cadwaladr area)	**285**	**40**	**272**	**12**
Central and West Wales: (Powys, Hywel Dda , Abertawe Bro Morgannwg areas)	**223**	**18**	**513**	**23**
South East Wales: (Aneurin Bevan, Cardiff & Vale, Cwm Taf areas)	**486**	**23**	**658**	**46**
NHS Direct Wales	**56**	**2**	**159**	**0**
TOTAL	**1050**	**83**	**1602**	**81**

*Includes clinical negligence, personal injury & personal injury from road traffic collisions.

Table 3: Concerns received by Type (Complaints)

Concern Type	2012/13	2013/14
Formal Complaints (Regulation 24)	463	369
Formal Complaints (Regulation 26)*	35	54
Joint Responses with Health Boards	68	83
On The Spot Concerns	312	627
TOTAL	**878**	**1133**

*cases include those managed through the Redress process but resulting in Regulation 24 responses

Table 4: Concerns in relation to Trust activity

Service Area	Trust Activity 2013-2014	Complaint	Incident
EMS (999 calls)	444,363	1 in 836 calls	373
PCS (journeys)	764,433	1 in 1,464 journeys	3,803
NHSDW (calls)	317,415	1 in 5,473 calls	1,996

This means a complaint is raised on average once in every 836 999 calls, once in every 1,464 PCS journeys and once for every 5,473 NHSDW calls.

Table 5: Primary Subject of Complaint

Complaint Subject	Complaint 2013/14	Joint HB Complaint 2013/14	2012/13 Percentages	2013/14 Percentages
Medical Priority Despatch System (999 priority system)	16	4	3%	2%
Attitude	145	5	12%	13%
Clinical care	28	9	3%	3%
Communication	105	7	3%	10%
General care	51	10	2.5%	5%
Other	66	8	15%	7%
Service provision	186	9	7%	17%
Standard of driving	42	0	4%	4%
Timeliness	360	25	47%	34%
Vehicle	50	6	3%	5%
Welsh language	1	0	0%	0.08%
TOTAL	**1050**	**83**	**100%**	**100%**

If a complainant raises more than one issue in their concern, for example poor driving and poor communications, the main subject of the concern has been captured only.

Table 7: Formal Complaint Acknowledgements

	Formal Concerns 2013/14*
* data measured by acknowledgements due in the financial year	
Formal complaints acknowledged within 2 working days of receipt of the complaint.	353 (81%)
TOTAL	**435**

Table 6: Subject of Incident

Patient Safety Adverse incident category	Received 2012/13	Received 2013/14
Access, admission, transfer and discharge from hospital	530	445
Priority Dispatch Computer System Issues	223	147
Infrastructure (including staffing, facilities, environment)	96	76
Consent, interpersonal communications and confidentiality	62	73
Equipment or Medical Device Issue or Failure	129	117
Patient has slipped, tripped or fallen whilst in Amb care	84	71
Issue reported with treatment or procedure provided	40	59
Patient hurt from contact with object or hazard	43	73
Medication / Drugs / infusion	38	45
Child Welfare Issues Identified	16	12
Protection of Vulnerable Adults Issues Identified	59	57
Implementation of care and ongoing monitoring / review	16	15
Issue raised with clinical assessment / diagnosis / tests	71	34
Patient records or documentation issue	21	21
Infection control or decontamination incident	21	30
NHS Direct telephone triage tool issue	119	35
Radio & Telecommunications issue	88	73
Patient Mental Capacity Issues	0	10
Deployment of staff or ambulance to incident issue	214	175
Disruption of normal services by abnormal event	15	7
Patient Self Harming whilst in Trust care	0	13
Other	41	14
TOTAL	**1926**	**1602**

During 2013/14 the Trust received 1602 adverse incident reports (i.e. any unintended or unexpected incident which could have, or did, lead to harm). 38 cases were submitted by the Trust to Welsh Government as Serious Adverse Incidents. These include incidents such as unexpected or avoidable death, severe/permanent harm, and transmission of infectious diseases or allegations of actual abuse. The Trust actively encourages staff to report all adverse incidents, near misses and hazards even though they seldom result in harm to any person. This is to ensure learning takes place.

Table 8: Formal Complaint Response Performance

Cases that did not involve issues of liability (Regulation 24)

	Formal Concerns 2013/14
* data measured by responses due in the financial year	
Complaints receiving a final response within 30 working days of receipt	128 (30%)
Complaints receiving a final response within a period exceeding 30 working days but within 6 months of receipt	208 (48%)
Complaints where the final response exceeded 6 months of receipt	97 (22%)
TOTAL	433

Table 9: Formal Complaint Response Performance

Cases where there is or may be a qualifying liability (potential Regulation 26)

	Complaints 2013/14
Complaints handled through the Redress process as potential Regulation 26	54 (5% of all complaints received)
Complaints handled through the Redress process closed	23* (31 cases remain open)
Complaints confirmed as Regulation 26 requiring Redress as part of their resolution	2/23 (9%)
Regulation 26 cases responded to within 6 months	1/2 (50%)

Compliments

Table 9 – Compliments by Area

Area	2012/13	2013/14
North Wales	126	216
Central & West Wales	74	123
South East Wales	45	164
NHSDW*	11	15
TOTAL	256	518

* A new process has been introduced to capture NHSDW compliments for reporting purposes so the figures are reflective of compliments received since Feb 2014

Final Concern Grading

Table 10 – Formal Complaints by Grading (closed complaints only)

Area	2012/13	2013/14
Grade 1 – No Harm	22 (5%)	130 (25%)
Grade 2 – Low Harm	128 (28%)	233 (45%)
Grade 3 - Moderate Harm	119 (26%)	134 (26%)
Grade 4 – Severe Harm	12 (3%)	13 (3%)
Grade 5 – Potential Death	4 (1%)	4 (1%)
Ungraded	179 (38%)	0 (0%)

Assurance

Welsh Risk Pool Services (WRPS) Annual Assessment

Since the introduction of the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, all Trust's and Health Boards in Wales are subject to an annual assessments of complaints, claims and learning from events by the Welsh Risk Pool Services.

The annual assessment is split into three areas: management of concerns, management of claims and learning from events. The assessment scores published in summer 2013 for 2012/13 were:
92.48% for compensation claims management,
89.32% for concerns management and
39.08% for learning from events.
Overall compliance to the standard was 73%.

In response to the assessment, a work plan has been implemented to put in place the improvements identified in the achievements section of this annual report.

The next assessment is being undertaken in June 2014 with the report planned to be released to the Trust in autumn 2014.

This information will be provided in our 2014/15 Concerns Annual Report.

Public Service Ombudsman (Wales)

The role of the Public Services Ombudsman (Wales) is to consider complaints made by members of the public where they believe that they have suffered hardship or injustice through maladministration or service failure on the part of a body within the Ombudsman's jurisdiction.

During 2013/14, 18 concerns against Welsh Ambulance Services NHS Trust were escalated to the Ombudsman. Of these cases:

- 6 were escalated prematurely,
- 6 cases were closed after initial consideration,
- 1 case was out of the Ombudsman's jurisdiction,
- 3 cases were settled voluntarily,
- and 3 cases were investigated with only 1 case upheld.

This is an improvement to last year with only three investigations conducted by the Ombudsman's Office and only one case upheld.

In this case learning was identified by the Trust with regards to work required in Green priority cases to enable our Nurse Advisors to influence the level of emergency response required independently on our Medical Priority Dispatch System (MPDS), where the nurse has clinical knowledge that has not been gathered as part of the MPDS process.

The Trust has actioned in full the findings and recommendations as set out by the Ombudsman and will continue to work closely with the Public Service Ombudsman's Office to improve quality in the investigation of concerns. The Trust provides a quarterly concerns report to the Ombudsman's Office to provide assurance of concerns handling and service improvements.

Trends & Themes

This year, the Trust has seen an even split in the number of concerns received between our main services, with 47% of concerns received regarding our Emergency Medical Services (EMS) and 46% of concerns received regarding our Patient Care Services (PCS) Transport. The concerns regarding NHS Direct Wales have increased from 3% to 6% this year (Table 1).

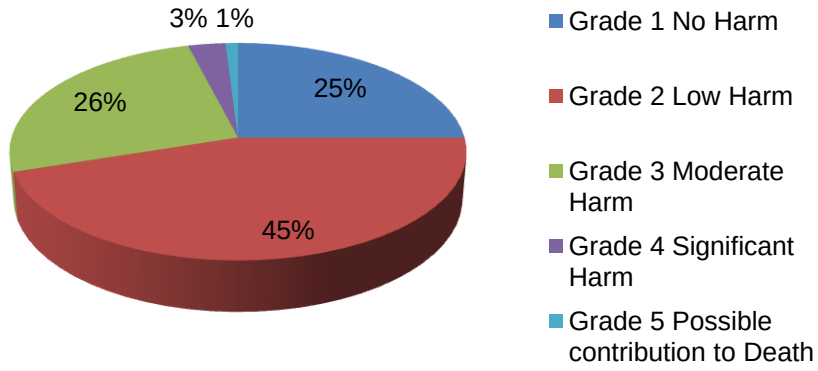
The main subject of complaints remains as timeliness this year. However, the percentage of complaints regarding timeliness has reduced from 47% to 34% this year, with an increase in service provision complaints from 7% to 17%. This may be as a result of more information being available to the public on the services that we are commissioned to provide.

The Trust has seen an increase in the number of clinical negligence and personal injury claims from 74 last year to 81 this year. This is the first year that the Trust has seen an increase since 2009/10.

The number of incidents reported by staff has reduced this year, however we have seen two new categories of incidents, these are where patients have self harmed whilst in Trust care and where an incident has occurred involving a patient with a mental capacity issue.

The Trust has implemented new processes to ensure that all concerns have a harm grading when they are received and have their grading reviewed on completion of the investigation, to ensure correct levels of harm are recorded. We have increased the number of complaints graded from 62% to 100% this year.

The additional 38% of complaints graded this year has increased cases in the no harm category and low harm category. Percentages of concerns in the moderate harm and above categories remain consistent with last year's figures (Table 10).



Organisational Learning

The outcome of concern investigations provide information for the Trust to gather intelligence regarding the things that need to be improved or changed as a consequence.

In November 2013, the Trust approved an Organisational Learning Policy to support learning from concerns. A significant mechanism for learning within the policy is the Organisational Learning Group which was established in April 2014.

The Patient Safety Team and Putting Things Right Team have analysed the concerns received in 2013/14 to present the trends and themes to the Organisational Learning Group. Work has now been implemented to research these areas further to introduce plan, do, study, act cycles into these areas to make changes and measure their effectiveness.

Lessons have been learned from concerns in lots of areas across the Trust this year. A few examples are:

Clinical Contact Centres
Work has been undertaken within the Clinical Contact Centres this year and this is reflected in the significantly positive reduction in the number of incidents reported by staff in the areas of the Medical Priority Dispatch Computer System and the NHS Direct Wales telephone triage computer tool.

Improved Communication
We have increased the opportunities for patients and their families to speak with members of Trust staff to discuss their concerns on the spot at the point when they arise.

Palliative Care
We have increased awareness with our operational staff of the requirements of palliative care patients and their families.

Clinical Response Model
We have increased the information that we provide in our concern responses to ensure that the person raising the concern understands our clinical response model.

Continued Professional Development Programme
Themes and trends from concerns have been used to determine additional areas that have been included into staff training. Patient Safety Managers have been demonstrating the importance of learning from concerns in induction training for our Clinical Team Leaders.

Clinical Bulletins
Where a trend involving clinical care is identified, clinical bulletins are circulated quickly to all operational staff to ensure that they are aware of the issue and how to mitigate risks to patient safety.

Testing of New Equipment
Through the monitoring of incidents reported nationally by staff, we were able to pick up faults with new equipment being tested, to resolve them quickly.

Looking Forward

In the coming year, we are working towards recording more information on the outcomes from concern investigations to understand which of the concerns raised with us are founded and unfounded. This information will be used to identify where service improvements are needed to improve our services and the experience of our service users. This information will also tell us where we need to work with our service users to improve the information available to the public regarding the services that we are commissioned to provide.

This summer, we will begin contacting people who have raised a concern with us to gather their feedback and their views on the processes that are in place to deal with concerns. This information will be used to improve the way concerns are handled from the perspective of the person raising the concern.

Having increased access to raise a concern generally this year, we are now working with our Partners in Health Team to improve access for people with sensory loss to raise a concern with us.

We will continue to review our re-opened cases with a view to reducing the number of these cases in the coming year. By focusing on feedback received this year we will increase the contact that we have with the person raising the concern, offer a meeting with Trust staff where possible and reduce the complex language that we use in some more technical complaint responses, to increase the assurance and complainant satisfaction with our responses.

The Welsh Government have commissioned a review of how Putting Things Right has been implemented and managed within the health organisations in Wales. This review has incorporated the views of members of the public and will be released with recommendations regarding the management of concerns under the Regulations in the future.

The Welsh Risk Pool Services second annual assessment of the Trust will be on 10th June 2014. The assessment will include auditing complaints and claims with a predominant focus on organisational learning this year. The report will be released in the autumn of 2014 and will require the Trust to implement recommendations over the coming twelve months.

The most exciting development this coming year will be with the newly established Organisational Learning Group which provides a platform for identifying and prioritising learning and service improvements from concerns. This will provide us with robust governance around the changes that we make as a direct result of the concerns raised with us and will provide assurance to the public that we are a learning organisation.