Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	13 August 2020
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Claims Management Report – High Value/Novel Claims
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mandy Rayani, Director of Nursing, Quality & Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Louise O'Connor, Assistant Director (Legal and Patient Support) Gaynor Kynaston, Head of Legal Services

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

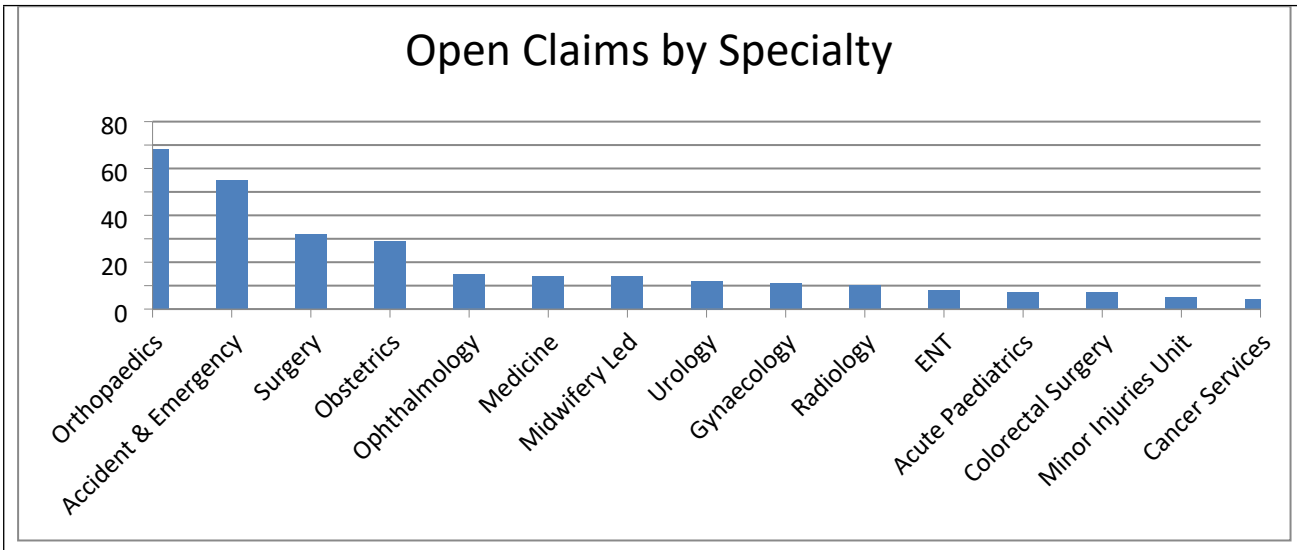
The Quality, Safety and Experience Assurance Committee is required to receive decisions made with regard to significant claims against the Health Board, valued in excess of £100,000, or valued under £100,000, but which raise unusual issues or may set a precedent. The Committee is also required to ensure that the learning from such cases is considered, with relevant actions agreed as appropriate.

This report provides a summary of the current clinical negligence claim caseload, and cases valued in excess of £100,000. There are no novel claims which need to be reported for this period.

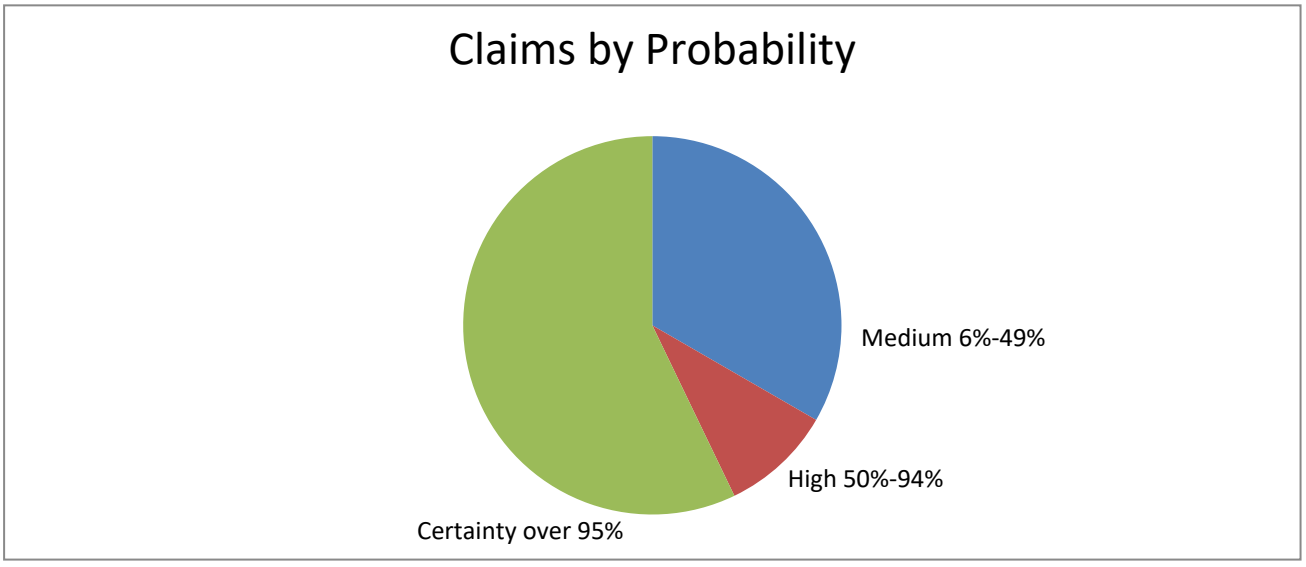
In relation to outcomes and themes arising from claims, this will be provided by the Listening and Learning Sub-Committee.

Cefndir / Background

The Health Board currently has 349 open claims. The open claims by specialty are as follows:



Twenty two of these cases have been settled. The claims that have been reviewed for probability, based on information provided by the claimant thus far have been evaluated as follows, however will be subject to change as further information becomes available:



Between 1st April and 30th June 2020, 7 cases have been closed. One of these cases has been settled in excess of £100,000 (including damages and claimant costs), which related to a delay in diagnosis/treatment in the field of gynaecology. The learning and assurance in respect of the closed claim has been submitted to the Welsh Risk Pool and reimbursed. The Committee is also reminded that the Health Board is liable to pay the first £25,000 of these costs.

The Health Board is operating the revised reimbursement procedures introduced by the Welsh Risk Pool, which involves a learning from event form being issued within 60 days of admissions being made in a case. Evidence of learning, and case management reports are also provided prior to closure of the case, before consideration will be given by the Welsh Risk Pool to reimburse the costs incurred. Decisions to defer or reject reimbursement will be made unless satisfactory evidence of learning has been produced.

Issues of significance to the Health Board in respect of learning from claims include:

Missed fractures/dislocations: work has been undertaken within the emergency departments and the trauma and orthopaedic teams in relation to management of fractures,

specifically in relation to the management of bony wrist injuries and scaphoid fractures. Any person attending the emergency department will be followed up in a fracture clinic, rather than the emergency unit.

Falls: this includes risks not identified when assessments are undertaken and confusion not being escalated appropriately. Cases of avoidable inpatient falls and falls management will be reviewed on a quarterly basis by the Listening and Learning Sub-Committee. A corporate improvement plan for falls is being developed in response to themes occurring across the Health Board area.

Hospital Acquired Thrombosis (HAT), including delay with International Normalised Ratio (INR) assessment following admission, failure to note previous thrombosis, delay with Venous thromboembolism (VTE) assessment and failure to prescribe heparin medication to take at home. The Health Board is undertaking improvement work to minimise the risk of such incidents occurring.

Missed diagnosis, including delay in identifying tumours, following incidental findings on images for investigation of unrelated symptoms. The main concerns relating to this include the review of test / diagnostic results by the appropriate clinician. All clinicians have been reminded of their responsibility in this regard and an improvement initiative is being undertaken to consider a technological and systemic process to ensure results are reviewed and acted upon in a timely manner. Any incidental findings from tests results should also be notified to the relevant multidisciplinary team (MDT), rather than individual clinicians.

In all of the above areas, learning has not been finalised and further work is required to ensure all learning and assurance plans are robust, with evidence of implementation. This has been included in the work plan for the Listening and Learning Sub-Committee. The Welsh Risk Pool will not reimburse the Health Board without such evidence and plans for ongoing review. There have been a number of cases recently returned due to insufficient assurances around learning from claims and redress cases. There are a number of risks to the Health Board:

- Further issues of a similar nature will recur, jeopardising patient safety;
- Reimbursement will not be approved if learning does not satisfy Welsh Risk Pool, which will pose a significant financial risk to the organisation;
- Reimbursement will not be approved where there are no assurances from a particular event, and further claims are made raising the same themes.

The Listening and Learning Sub-Committee will aim to review the learning of matters prior to submission to the Welsh Risk Pool and provide assurances to the Committee that the learning is being scrutinised.

A revised learning from events process will be implemented across the organisation, focusing on strengthening of action planning, together with the ongoing monitoring of implementation and impact.

Asesiad / Assessment

From the assessment of the higher value cases that have been closed during the period, all cases have been submitted to the Welsh Risk Pool for reimbursement. However the Legal Services Team will continue to work closely with the operational teams to strengthen the learning systems and submission of satisfactory evidence across the Health Board.

The Listening and Learning Sub-Committee will review all such cases prior to submission to the Welsh Risk Pool, for assurance of learning actions and monitoring arrangements. Themes/trends following triangulation of experience and patient safety information will be reported to the Committee, as part of the assurance reporting process.
Argymhelliad / Recommendation The Committee is asked to note the Claims Management Report – High Value/Novel Claims.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.20 Receive decisions made with regard to significant claims against the Health Board, valued in excess of £100,000, or valued under £100,000, but which raise unusual issues or may set a precedent, and ensure that the learning from such cases is considered, with relevant actions agreed as appropriate.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	n/a
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 2. Safe Care 3. Effective Care

Effaith/Impact:	
Ariannol / Financial: **Ansawdd / Patient Care:** **Gweithlu / Workforce:** **Risg / Risk:** **Cyfreithiol / Legal:** **Enw Da / Reputational:** **Gyfrinachedd / Privacy:** **Cydraddoldeb / Equality:**	N/A