



**AGENDA ITEM**

3.2.4

**CTM BOARD**

**PUTTING THINGS RIGHT ANNUAL REPORT 2020/2021**

<b>Date of meeting</b>	30/09/2021
<b>FOI Status</b>	Open/Public
<b>If closed please indicate reason</b>	Not Applicable - Public Report
<b>Prepared by</b>	Louise Mann, Assistant Director Quality, Safety & Safeguarding Sharon O'Brien, Assistant Director of Nursing & People's Experience
<b>Presented by</b>	Greg Dix, Executive Director of Nursing
<b>Approving Executive Sponsor</b>	Executive Director of Nursing
<b>Report purpose</b>	FOR NOTING

**Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)**

<b>Committee/Group/Individuals</b>	<b>Date</b>	<b>Outcome</b>
Quality & Safety Committee	09/08/2021	NOTED

**ACRONYMS**

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## 1. SITUATION/BACKGROUND

*Putting Things Right (2013)* was established to review the existing processes for the raising, investigation of and learning from concerns. 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. The aim is to provide a single, more integrated and supportive process for people to raise concerns which:

- Is easier for people to access;
- People can trust to deliver a fair outcome;
- Recognises a person's individual needs (language, support, etc.);
- Is fair in the way it treats people and staff;
- Makes the best use of time and resources;
- Pitches investigations at the right level of detail for the issue being looked at; and
- Can show that lessons have been learnt

The purpose of this report is to provide the Board with a summary of Putting Things Right (PTR) within Cwm Taf Morgannwg University Health Board (CTMUHB) including complaints, incidents, compliments claims and redress between 1<sup>st</sup> April 2020 and 31<sup>st</sup> March 2021.

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

This reporting period has been a very challenging year due to the COVID 19 pandemic within the Health Board and its communities. The Health Board has implemented new ways of working and models of care in order to respond and meet the extreme and unprecedented pressure that the Health Board has experienced in this reporting period. However, the Health Board has strived to respond and support patients, their families and staff in relation to their experiences and needs during this difficult time.

The creation of ILG's (Integrated Locality Groups), has enabled the Organisation to allow closer management and ownership of concerns at a more local level. Thus, creating greater ownership and accountability, fostering a learning and improvement culture with the ability to create changes at local level for the benefit of patients and staff.



### **3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE**

#### **People's Experience**

The Covid-19 pandemic and the necessary cessation of hospital visiting during this time period impacted greatly on the Health Board's ability to communicate with families about their loved ones, particularly in the acute settings. The Health Board explored a number of avenues to alleviate this with virtual visiting, inpatient/outpatient leaflets, laundry drop off services, bereavement support and continues to review how we can improve this.

#### **Concerns**

On reviewing the data, the top five themes and trends for this reporting period were:

- Communication
- Delays
- Treatment Error
- Admission, transfer or discharge
- Security/property

These themes are drilled down further within each ILG for their ILG Quality & Safety meetings on a monthly basis and reported as part of their Executive Performance Reviews.

#### **Redress & Claims**

During the early part of this reporting period the Health Board was facing significant challenges in relation to ensuring that its process and procedures in relation to claims and redress were meeting the Welsh Risk Pool (WRP) requirements.

This was compounded by a large backlog in Case Management Reports and Learning from Events Report (LFER) submissions to WRP. In early 2020, there were 289 outstanding LFER for claims with 40 Redress Legacy outstanding. In July 2020 a small task force was established in an attempt to address the backlog. The Health Board also reviewed and updated all its processes and procedures in relation to Claims and Redress. By 31<sup>st</sup> March 2021, only 38 LFERs remained outstanding and work continues to ensure that learning is evidenced to enable closure of all these cases by July 2021.



## Patient Safety Incidents and Reportable Serious Incidents

During this reporting period, 20,435 patient safety incidents were reported. The top reported patient safety incidents were as pressure damage at 23%, slip trip or fall at 16% and delays at 10%.

The Health Board had 188 serious incidents occur during this reporting period. A spike seen in December 2020 reflects changes in the way Health Boards reported Covid-19 Health Care Acquired Infections after this date.

### 4. IMPACT ASSESSMENT

<b>Quality/Safety/Patient Experience implications</b>	Yes (Please see detail below)
	Patient care and staff experiences
<b>Related Health and Care standard(s)</b>	Safe Care
	All Health care standards affected
<b>Equality impact assessment completed</b>	Not required
<b>Legal implications / impact</b>	There are no specific legal implications related to the activity outlined in this report.
<b>Resource (Capital/Revenue £/Workforce) implications / Impact</b>	There is no direct impact on resources as a result of the activity outlined in this report.
<b>Link to Strategic Well-being Objectives</b>	Provide high quality, evidence based, and accessible care

### 5. RECOMMENDATION

The Board is asked to:

- **NOTE** the position of the Health Board with regard to the Putting Things Right Annual Report 2020/21
- **NOTE** the areas of good practice that have been reported within this paper and areas for improvement.