Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

PUTTING THINGS RIGHT

Annual Report 2020/2021

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PUTTING THINGS RIGHT ANNUAL REPORT 2020/2021

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Executive Summary

1304 Formal Complaints Received

5656 Redress

86 Claims

62 Ombudsman

20435 Patient Safety Incidents

188 Serious Incidents

2 Never Events

864 Compliments

PUTTING THINGS RIGHT ANNUAL REPORT 2020/2021

1.0 Introduction

The purpose of this report is to provide the Board with a summary of people's experience with Cwm Taf Morgannwg University Health Board (the Health Board) including complaints, incidents, compliments claims and redress between 1st April 2020 and 31st March 2021.

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

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.

2.0 How we manage concerns

The Health Board has a Concerns Management policy to support the effective management of complaints, patient safety incidents and redress. It is supported by the Health Board's incident reporting policy and procedure and should be read in conjunction with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and Putting Things Right Guidance (2013). This policy is supported by a number of action cards and a serious incident toolkit.

The Health Board has made arrangements to ensure our patients, public and staff know how to raise their concerns, this includes links on media, posters, patient leaflets in our hospital sites.

Following a review of Health Board's internal governance structures and 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.

We have also engaged with the Ombudsman and Welsh Risk Pool who have provided training around responding to concerns, learning, customer service etc to continue the learning culture the organisation continues to foster.

3.0 Complaints

The Health Board has continued to strive to respond and support patients, families and carers alike when replying to concerns within the Putting Things Right Guidance.

Any complaint raised should be responded to within 30 working days. Some complaints can be more complex and takes a little longer to provide a detailed response.

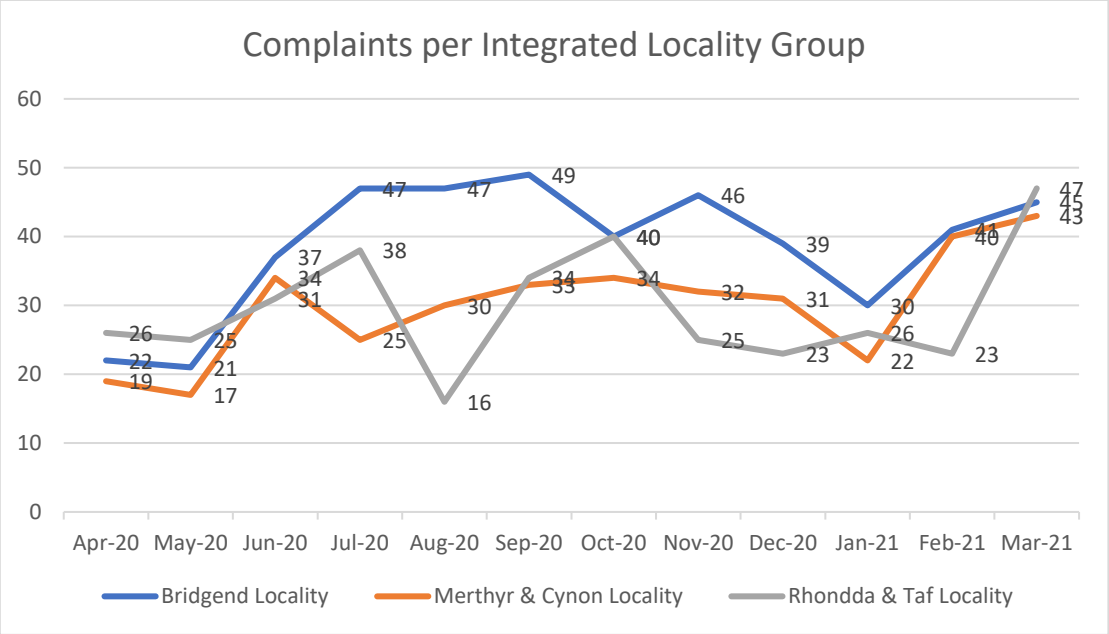
Total Formal Complaints Received	Total
Bridgend Locality	464
Merthyr Cynon Locality	360
Rhondda Taf Ely Locality	354
Corporate Function/Operational	126
TOTAL	**1304**

Complaint	2020/21
2 working day acknowledgement	554
30 working day response	750

	Formal PTR - over 2 days - proportionate handling	Formal PTR - including regulation paragraph	Total
Bridgend Locality	177	287	464
Merthyr & Cynon Locality	156	204	360
Rhondda & Taf Locality	176	178	354
Corporate Function / Operations	45	81	126
Total	**554**	**750**	**1304**

The line graph below notes number of complaints per Integrated Locality Group.

However, service design and activity must be considered when reviewing this data, particularly as this is during the pandemic period when some services were stepped down or centralised.



When reviewing complaints, an analysis takes place to try to identify themes and trends. In doing this, it enables identification of areas for learning and improvement.

Top 5 Complaints by Locality	Bridgend Locality	Corporate Function / Operations	Merthyr & Cynon Locality	Rhondda & Taf Locality	Total
Communication	188	43	99	99	429
Delays	95	27	66	95	283
Treatment Error	60	26	99	60	245
Admission / Transfer / Discharge	51	1	27	36	115
Security - Property	15	0	16	15	46

In April 2021 the complaints response template was updated to ensure it was standardised. In addition, supporting information regarding Putting Things Right has been produced, as well as a new policy for Handling Persistent and Serial Complaints. This sets out the Health Board's Policy for dealing with persons who act in an unreasonable and persistent way in continuing to complain despite their grievances having already been addressed proportionally by the Health Board.

A new authorisation processes for Complaints/Enquiries from MP's, MSs, Cllr's & Representatives has also been introduced.

4.0 Redress

Within the PTR guidance, if during the investigation of a complaint a breach of duty in our care has been identified which has caused the patient harm, there may be a qualifying liability. The complaint will move into Redress to undergo further detailed investigation.

Out of the 1304 formal complaints received between 1st April 2020 and 31st March 2021, 20 were referred to Redress with a total of 4 identified as having a qualifying liability. *1 Redress case was transferred to a Claim.*

5.0 Claims

If a case is of high value over £25,000, it will be managed as a claim. There are two types of claims, clinical negligence or personal injury.

During 1st April 2020 to 31st March 2021 there were

Claims	Total
Clinical Negligence	42
Personal Injury	44

6.0 Inquests

An inquest is a formal investigation by the Coroner to determine how somebody died. Inquests are only held in certain circumstances, such as if the death was sudden or unexpected. The Health Board will provide the Coroner with information to assist with inquests.

There were 183 inquests received with 56 taking place and concluding.

The Coroner has the power to make a report to prevent future deaths, which is provided under Regulation 28 Coroners Regulations 2013, which is why they are referred to Regulation 28 reports. The Health Board have not received any Regulation 28 reports.

7.0 Public Service Ombudsman for Wales (PSOW)

The Public Service Ombudsman for Wales (PSOW) has the power to review complaints about public services in Wales. If a complainant is not content with the Health Boards response, they can request the PSOW to review the case independently.

Between 1st April 2020 and 31st March 2021 there have been 62 Ombudsman cases received by the Health Board.

The PSOW decided to fully investigate 24 cases, with 6 enquiries where the Health Board were requested to provide further information. 32 cases were not investigated by the PSOW.

Ombudsman Cases Received by Locality	
Bridgend Locality	21
Merthyr & Cynon Locality	23
Rhondda & Taf Locality	13
Corporate Function / Operations	5
Total	**62**

Themes identified from Ombudsman cases are outlined below:

Communication	23
Treatment Error	20
Delays	8
Admission / Transfer / Discharge	6
Unexpected Complications	2
Health Records	1
Equipment	1
Patient injury	1
Total	**62**

Of the 61 cases received from the PSOW, 4 responses have been received, 2 were not upheld, 2 were upheld.

The remaining cases are still under investigation.

The Health Board received 2 Section 21 reports, whereby the Health Board agreed to make any necessary changes required as per the recommendations.

8.0 Patient Safety Incidents and Reportable Serious Incidents

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. The Health Board encourages staff to report any patient safety incidents, as it helps them to learn from mistakes and to take action to keep patients safe.

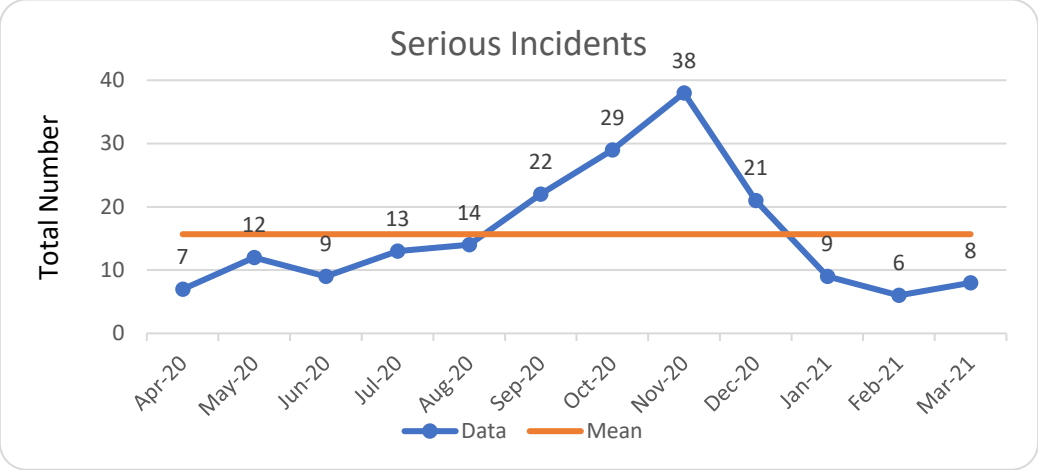
During 1st April 2020 to 31st March 2021 20,435 patient safety incidents were reported. These were split by locality below.

Patient Safety Incidents by Locality	Total
Bridgend Locality	7818
Rhondda & Taf Locality	6102
Merthyr & Cynon Locality	5946
Corporate Function / Operations	569
Total	**20435**

The top reported patient safety incidents were as pressure damage at 23%, slip trip or fall at 16% and delays at 10%

Most patient safety incidents have no harm or minor harm, however there are some more serious incidents which require external reporting to the NHS Wales Delivery

Unit. The Delivery Unit will provide oversight to the management and learning from serious incidents.



The Health Board had 188 serious incidents occur during 1st April 2020 to 31st March 2021. A spike seen in December 2020 reflects changes in the way Health Boards reported Covid-19 Health Care Acquired Infections after this date. The Health Boards Serious Incidents are split by locality below:

Serious Incidents by Locality	**Total**
Bridgend Locality	72
Merthyr & Cynon Locality	66
Rhondda & Taf Locality	43
Corporate Function / Operations	7
Total	**188**

Prompt addressing, making safe and investigation of patient harm continues to ensure good quality care provision is maintained and the learning shared. During this reporting period the criteria for SI's was relaxed by WG/DU as HB's managed the impact of the pandemic. The investigations carried were to be robust but proportionate to the incident being reviewed.

As an Organisation we have maintained the now removed external 60 day target for SI management to further improve upon our timescales for investigation and closure wherever possible. Overall UHB mean compliance rate with the 60 day target is 22% representing a very modest increase on compliance in previous years. ILG's are working with the central team to develop realistic improvement targets. Changes to the notification and management of incidents, including greater proportionality of investigation methodology according to severity of incident and flexibility of timescales for completion will be in use from June 14th 2021.

9.0 Never Events

Never Events are patient safety incidents that are wholly preventable where there is guidance and safety measures that provide strong systemic protective barriers available at a national level.

Never events have the potential to cause serious harm or death, although serious harm or death does not have to occur for it to be classed as a never event.

The Health Board had 2 never events between 1st April 2020 and 31st March 2021, these were in relation to

- One retained foreign body identified post operatively involving a patient receiving care at CTMHB and at the Royal Marsden Hospital. It is likely that there is no fault in respect of CTMHB and a joint investigation lead by the central team is in progress.
- Retained foreign body post procedure, whereby a guiding plate for a wrist plate, was left in situ. These should have been removed after drilling takes place.

10.0 Peoples 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.

In order for services to continue to meet the needs of the communities we support, there was a need to adapt their working practices'. Our Chaplaincy service extended their support within the Bereavement Team to provide pastoral and spiritual care to families in their time of need, whilst also ensuring this support was provided to patient's/families in all our acute settings via a number of different methods ie: virtual, telephone.

The volunteer service whilst unable to continue in their roles, adapted the services they could continue to support and assisted local community volunteer centres with shopping, picking up prescriptions and chatter lines. They have also supported virtual visiting for services ie: Dietetics and Nutrition and continue to ensure that the community is supported when attending the vaccination sites via meet and greet, marshalling services.

Carer's services linked in with the respective County Councils within the Health Board's remit to work collaboratively in improving support, information and recognition of Carer, whilst making best use of a wide range of knowledge, expertise and support services currently in place.

The gathering of patient feedback from our communities also allowed the Health Board an opportunity to look at different avenues of gathering this information. The use of social media, via the Health Board's Facebook page, 'Have your say cards', Community Health Council surveys together with learning from concerns and incidents have contributed to the learning that is being taken forward. The Health Board has also invested in a new patient experience feedback system CIVICA which is currently being implemented and will allow the Health Board a greater insight into the services we provide. Once CIVICA is fully operational within the Health Board this will provide a greater more detailed oversight regarding our population feedback and experience

of the care and services we provide.

CIVICA

An All Wales procurement process was undertaken to acquire a service user feedback system for implementation with NHS Wales. Following a successful tender exercise, CIVICA have been awarded the contract for 4 years with the option to extend. The use of this system is not mandated, however the Health Board have agreed implementation and will be early adopters of the new system.

To support implementation of the CIVICA system within the Organisation a Service User Feedback Group has been established, chaired by the Assistant Director of Nursing & People's Experience. The group includes representation from a range of areas across the Health Board, including the Integrated Locality Groups, Primary Care and Equality & Diversity.

Whilst implementation of the system has continued to progress, some slippage in timescales have been realised. The shell of the Health Board's version of the CIVICA system has been built, and the population of surveys into the system has now commenced.

The Patient Reportable Experience Measures (PREM) surveys have been uploaded to the system. Links to the survey have been generated and are being tested with members of the Maternity Service Forum, while the automation function is finalised.

An electronic version of the Health Board's Have Your Say card has been generated within the system and work is progressing to enable service users to provide feedback via the organisations Intranet site from July onwards. This will operate in conjunction with the paper based versions of cards, which will be manually uploaded.

In order to ensure a coordinated structured approach, the priority for the next 12 months is to scope out the questionnaires required to inform the quality indicators, as well as the prioritisation of adding surveys to the system.

Whilst implementation of the system has continued to progress, some slippage in timescales have been realised. The shell of the CTM version of the Civica system has been built, and the population of surveys into the system has now commenced.

The Patient Reportable Experience Measures (PREM) surveys have been uploaded to the system. Links to the survey have been generated and are being tested with members of the Maternity Service Forum, while the automation function is finalised.

Compliments

Compliments are extremely valuable and are a source of learning. They are one measure of patient satisfaction and a reinforcement of what we are doing well.

Compliments by Locality	Total
Merthyr & Cynon Locality	472
Rhondda & Taf Locality	225
Bridgend Locality	165
Corporate Function / Operations	2
Total	**864**

We received the most compliments in relation to Prince Charles Hospital.

Top 5 Sites for Compliments	Total
Prince Charles Hospital	440
Royal Glamorgan Hospital	177
Princess of Wales Hospital	131
Dewi Sant Hospital	35
Tonteg Site	17

11.0 Learning

Learning from 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.

There are a number of factors that contributed to the backlog for the Health Board, including:

- The number of outstanding claims that had already breached but also required the updated LFER
- New staff joining the team who required a period of induction as they had limited experience working in the NHS
- The need to ensure any new claims into the HB did not breach or become additional legacy claims. This resulted in a greater
- LFERs that had previously been sent to Speciality Directorates were now sitting within the new Integrated Locality Groups but had not been actioned in the required timeframes.

It became apparent that an alternative solution and urgent actions regarding processes would need to be implemented if the legacy claims were to be submitted by the WRP Committee deadlines. 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 31st March 2021, only 38 LFERs remained outstanding and work continues to ensure that learning is evidence to enable closure of all these cases by July 2021.

Improved communication has been established between the Welsh Risk Pool (WRP) and HB leads. The WRP Debtor Spreadsheet has been updated and rigorous scrutiny processes now ensure that is regularly shared with the Finance Department to ensure that the HB continues to meet the WRP Committee meeting deadlines.

The Health Board has been able to demonstrate learning for 69 of its claims and redress cases resulting in approximately £12 million being reimbursed.

Shared Listening & Learning Forum

The Shared Listening and Learning Forum has been established to provide oversight and assurance of the Health Board's framework for listening to and learning from incidents and patient/staff related concerns and experiences which promote and support a 'Just and Learning Culture'. The Listening and Learning forum reports to the Executive Management Board and is chaired by the Executive Director of Nursing. It champions a patient and staff safety culture and facilitates learning and sharing good practice. The forum's inaugural meeting was held in February 2021 with all ILGs presenting themes, issues and learning from incidents, claims and complaints (concerns). It is, too early for to judge the forum's effectiveness, and the impact it has made on patient experience and learning, but it is an important development in cross organisational learning to improve.

12.0 Summary

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.

Our voluntary services, chaplaincy and carers services continued to provide essential care and support to our communities and adapted their existing services to meet the needs of the population during the COVID pandemic.

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.