AGENDA ITEM
3.2.12

QUALITY & SAFETY COMMITTEE

ANNUAL REVIEW 2021/22 – WELSH RISK POOL AND LEGAL & RISK SERVICES

Date of meeting	15th November 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Stephanie Muir, Assistant Director of Concerns & Legal Services
Presented by	Georgina Galletly, Director of Corporate Governance
Approving Executive Sponsor	Director of Corporate Governance / Board Secretary
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Quality & Safety Committee	20/09/2022	Choose an item.

ACRONYMS	
PSOW	Public Services Ombudsman for Wales

1. SITUATION/BACKGROUND

1.1 The Welsh Risk Pool is a mutual body which supports all health organisations in NHS Wales by administering the risk pooling scheme, which provides the means by which all Health Boards, Trusts and Special Health Authorities in Wales are able to indemnify against risk. The role of the Welsh Risk Pool is to have an integrated approach towards risk assessment, claims management, reimbursement and

learning to improve. The team works with NHS colleagues across Wales to promote and facilitate opportunities to learn and support the development and implementation of improvements to enhance patient and staff safety and clinical outcomes.

1.2 Legal & Risk Services provide legal advice and representation for all health bodies in Wales. With specialist experience, knowledge and understanding of the legal, administrative and policy issues that affect the operation of the NHS in Wales, the Legal & Risk teams are able to support organisations in providing safe and efficient health and care services to the population of Wales.

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

2.1 The Annual Review reports the following in respect of CTM:

2.2 Open clinical negligence matters
In terms of trend CTM saw a steady increase from 2012-13 with open clinical negligence matters being 221, peaking at 293 in 2015-16, then reducing to around 200 in 2018-19, this has gradually increased to around 250.

2.3 In 2021/22 within CTM 53% of clinical negligence cases were successfully defended and closed without damages, this has been a slow but steady increase over the last three financial years. This sits at 10% higher than the all Wales average. Note: The report notes "closed without damages", however the graph title notes "closed with damages". This has been queried with WRP and clarified that 53% have been closed **without** damages.

2.4 In 2021/22 the principal clinical specialty identified in clinical negligence matters being managed within CTM was Maternity at 21.69%, Emergency Department at 15.66% and Trauma and Orthopaedics at 10.24%, which is in line with the top clinical areas for clinical negligence matters across Wales.

2.5 The number of open personal injury matters has remained steady within CTM over the past 3 years, with an average of 93.

2.6 In 2021/22 within CTM 47% of personal injury cases were successfully defended and closed without damages, this is a significant increase from 16% in 2019/20. The 2021/22 position is in line with the all Wales data.

2.7 Over the last 3 financial years, CTM have seen an increase in the number of redress cases being managed. However, it is clear that the closure rate of these cases remains relatively low.

2.8 The Health Board has made 15 periodical payments over the last five years totalling £1.3 million.

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

3.1 The Health Board are asked to:

- Receive the annual review
- Use information within the annual review to support the quality and safety agenda within CTM.
- Note that the Redress closure rate is relatively low, but take assurance that this has been noted and is being addressed through the operational model review and an invest to save bid.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Safe Care
	All Health and Care Standards Apply
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee is asked to receive and formally **NOTE** the annual review from Shared Services.