AGENDA ITEM
3.2.6

QUALITY & SAFETY COMMITTEE

PUTTING THINGS RIGHT ANNUAL REPORT 2021/2022

Date of meeting	19/07/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Stephanie Muir, Assistant Director of Concerns and Claims Louise Mann, Assistant Director of Patient Safety
Presented by	Stephanie Muir, Assistant Director of Concerns and Claims
Approving Executive Sponsor	Director of Corporate Governance
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	

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 Committee with a summary of Putting Things Right (PTR) within Cwm Taf Morgannwg University Health Board (CTMUHB) including complaints, incidents, compliments claims and redress between 1st April 2021 and 31st March 2022.

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

This reporting period has continued to be very challenging as we are moving out of the COVID 19 pandemic within the Health Board and its communities. 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 Health Board has implemented new ways of working and models of care and continue to evolve as we move into the endemic phase.

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

People's Experience

Whilst Covid-19 has continued to impact on how we were able to engage with the communities we support feedback has continued to be gathered from various sources such as virtual visiting, 'have your say cards', concerns, incidents, Community Health Council digital feedback surveys and the launch of the Civica patient feedback system in January 2022.

Concerns

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

- Clinical Treatment/Assessment
- Communication Issues (including language)
- Appointments

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 this reporting period the Health Board continued to face 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. WRP were invited by the Health Board to undertaken an independent review of our procedures for the management of claims, redress and inquests. The action plan in place to address the recommendations is monitored by the Quality & Safety Committee.

Patient Safety Incidents and Reportable Serious Incidents

During this reporting period, there were 25,350 incidents reported, of which 22,033 (87%) were patient safety incidents. Of the 22,033 patient safety incidents, 13,612 (62%) were deemed to have caused harm.

During 2021/22, the Health Board reported 61 Serious Incidents/Nationally reportable Incidents to Welsh Government.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Patient care and staff experiences
	Safe Care

Related Health and Care standard(s)	If more than one Healthcare Standard applies please list below:
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 yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
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

The Committee is asked to:

- **NOTE** the position of the Health Board with regard to the Putting Things Right Annual Report 2021/22