Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

PUTTING THINGS RIGHT

Annual Report 2021/2022

Assistant Director of Concerns & Claims
Assistant Director of Quality, Safety & Safeguarding
Head of Peoples Experience

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Executive Summary

1453 Formal Complaints Received

29 Redress Cases Received

72 Claims Received

84 Ombudsman Referrals made

25,350 Patient Safety Incidents

61 SI's/ NRI's, 122 LRI's Reported

4 Never Events Reported

929 Compliments Received

PUTTING THINGS RIGHT ANNUAL REPORT 2021/2022

1.0 Introduction

The purpose of this report is to provide a summary of people's experience with Cwm Taf Morgannwg University Health Board (the Health Board) including complaints, incidents, compliments claims and redress cases between 1st April 2021 and 31st March 2022.

Putting Things Right (2013) was established to manage the processes for 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.

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.

2.0 How we manage Concerns

The Health Board has a Concerns Management policy to support the effective management of complaints with associated Standard Operating Procedures in place to support teams, this is aligned with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and Putting Things Right Guidance (2013).

This year we launched a new triage process within the central concerns team to look at how we managed complaints within the Putting Things Right Guidance (PTR). As such, the Health Board was able to resolve a number of queries relating to waiting times, appointment queries etc with the support of the ILG governance teams and PALS teams, being managed as early resolutions rather than formal complaints. This has contributed to a reduction in formal concerns and the Health Board's ability to support patients/families in our communities at a much more local supportive level.

Following the publication of the National Quality & Safety framework by the Welsh Government in June 2021, the Health Board formulated an incident management toolkit to standardise the investigation processes and documentation throughout the Health Board. The Framework is set out with process maps and useful tools to walk managers through the investigation process. It also has useful links and contacts for managers to utilise within the investigation process for both family liaisons and staff. Alongside the incident management framework, a small information booklet for staff

who are not directly undertaking investigations has been developed outlining what to expect after they have reported an incident.

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 etc.

On 1st August 2021 the Complaints and Claims portfolio was moved to the Director of Corporate Governance. An Assistant Director of Concerns & Claims was appointed to provide strategic direction, leadership and oversee the function. The Executive Director of Nursing, Midwifery and Patient Experience continues to act as the responsible person for the Health Board in respect of the Putting Things Right Regulations.

In December 2021, the Health Board received a report following an independent review commissioned from the WRP into a 'Review of procedures for the management of claims, redress cases and coronial investigations'. The report was received at the Quality & Safety Committee where an action plan to address the recommendations was endorsed. Improvement work continues into 2022/23 to strengthen the health Board's resources and management of Redress, Claims and Inquests with progress monitored by the Quality & Safety Committee.

During the reporting period, the Health Board also received an Internal Audit Report on Management of Concerns. The management actions in place to address the recommendations arising from the audit are monitored by the Audit & Risk Committee and the Quality & Safety Committee of the Board.

3.0 Complaints

The Health Board are fully committed to resolving any complaint within 30 working days. However, some complaints can be more complex and take a little longer to provide a detailed response and we aim to resolve those within 6 months.

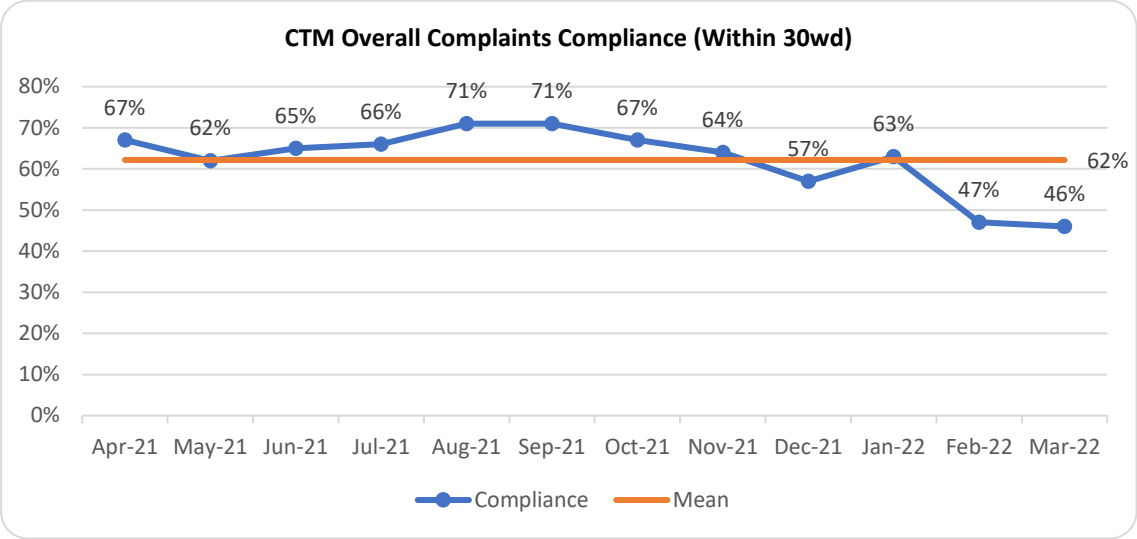
During the year, 1453 Formal Complaints were closed, we responded to 63% (916) of concerns received within 30 working days and 35% (506) within 6 months, 5% (70) were closed over 6 months.

Of the total complaints received during 1st April 2021 to 31st March 2022 - 175 Formal Complaints and 35 Early Resolution Complaints remain open.

Closed Complaints 2021/2022	Number
Total Number of complaints received and closed	3147 Received 3,132 Closed
Total managed via early resolution	1729
Total managed as formal	1418
Total formal responded to within 30 working days	916
Total formal responded to within 6 months	506

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

The following graph sets out the Health Board's monthly response compliance rates:



Complaints highlight various aspects of concern regarding our services and the care that we provide. This helps to identify emerging themes and trends in specific areas, where we can focus improvement work.

The following areas have emerged as themes over the past year:

Top 3 Themes	Total
Clinical Treatment/Assessment	525
Communication Issues (including Language)	280
Appointments	88

4.0 Redress

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 1453 formal complaints received between 1st April 2021 and 31st March 2022, 29 were referred to Redress. Of these, 2 have been closed with an outcome of no qualifying liability. It should be noted that Redress cases, will not always be transferred and closed within the same financial year. Therefore, the cases closed during 2021/2022 may have been received in previous years.

5.0 Claims

If a case is of a higher value than one that can be managed by Redress (ie over £25,000), it will be managed as a claim. There are two types of claims, clinical negligence or personal injury.

During 1st April 2021 and 31st March 2022 there were:

Claims	Total
Clinical Negligence	52
Personal Injury	20

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 180 inquests received during 2021/22 with 26 out of the 180 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.

During 1st April 2021 to 31st March 2022, the Health Board have received 4 Regulation 28s. Detailed actions and improvements have been undertaken to ensure compliance with the recommendations set out.

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 Board's response, they can request the PSOW to review the case independently.

Between, 1st April 2021 and 31st March 2022, there have been 84 Ombudsman cases received by the Health Board.

The PSOW decided to fully investigate 41 cases, with 15 enquiries where the Health Board were requested to provide further information. 25 cases were not investigated by the PSOW.

Ombudsman Cases Received by Locality	
Bridgend Locality	30
Merthyr & Cynon Locality	24
Rhondda & Taf Locality	22
Corporate Function / Operations	8
Total	84

Top Themes identified from Ombudsman cases are outlined below:

Treatment Error	30
Communication	22
Delays	6

Admission / Transfer / Discharge	6

Of the 84 cases received from the PSOW, 2 responses have been received, both cases were upheld.

The remaining cases are still under investigation.
The Health Board received 20 Section 21 reports during 1st April 2021 and 31st March 2022, with the Health Board agreeing to make any necessary changes required as per the recommendations.

8.0 Patient Safety Incidents and Reportable Serious Incidents

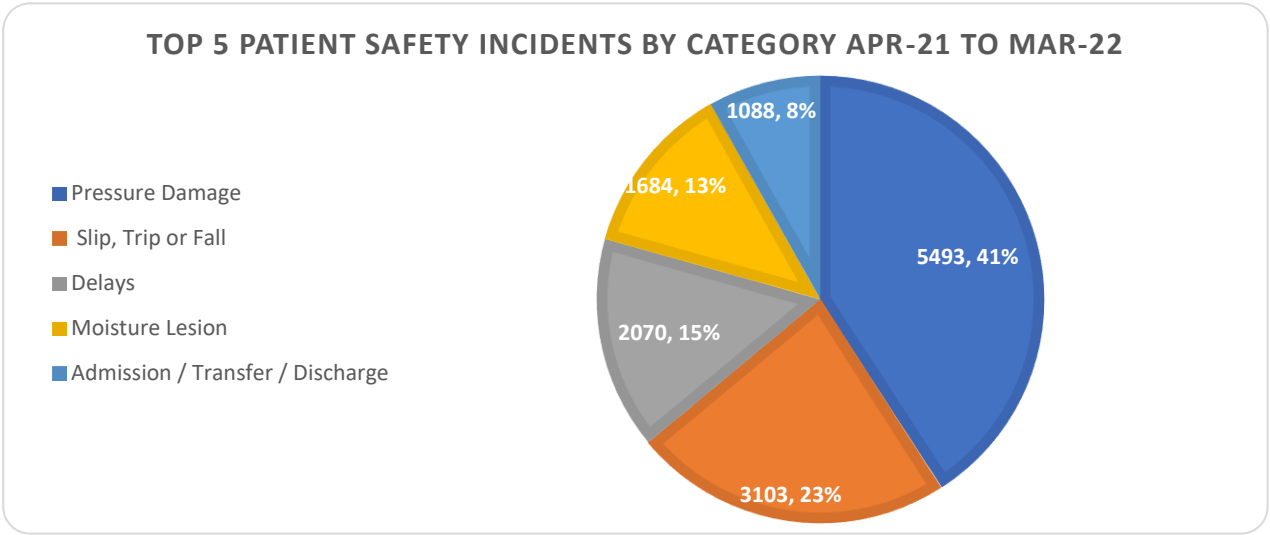
Effective management of patient safety incidents

It has been more important than ever during this period of significant challenge to place patient safety at the heart of our services. A weekly overview thematic report is produced by the Patient Safety Team for internal scrutiny and to inform our weekly Clinical Executives quality and safety meetings. There were 25,350 incidents reported between 1st April 2021 and 31st March 2022, 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.

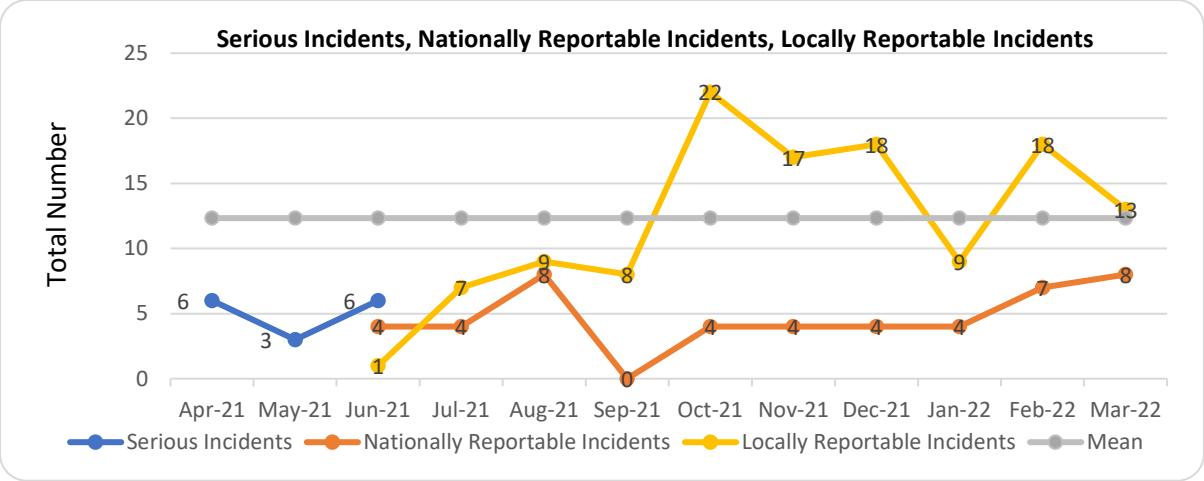
The following harm categories were recorded:

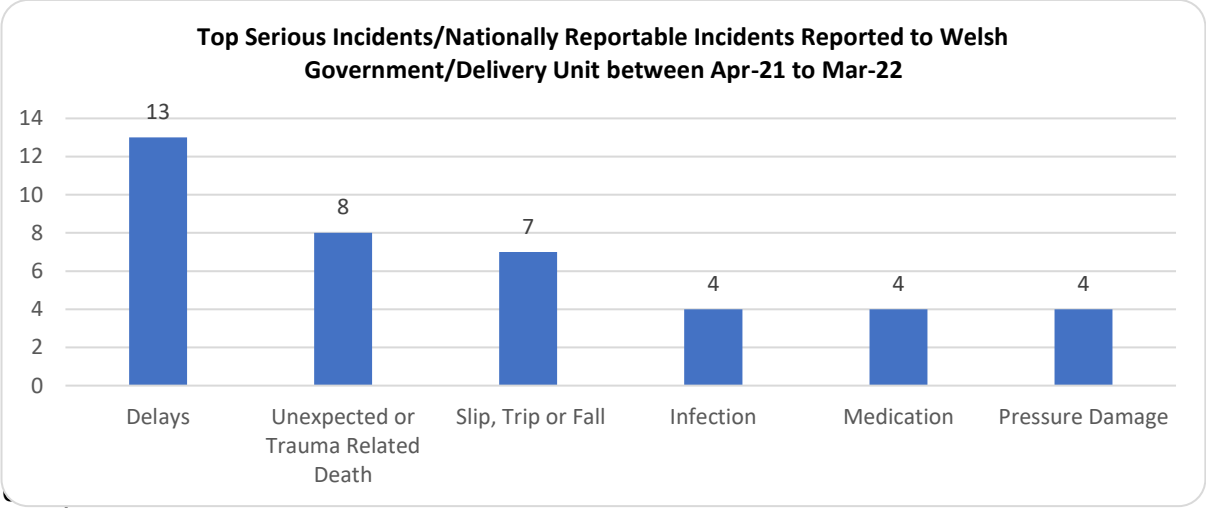
Level of Harm	Total Number
No harm	8,421
Low harm	9,817
Moderate harm	3,488
Severe harm	107

The top five Patient Safety incidents reported for the year are depicted in the chart below:

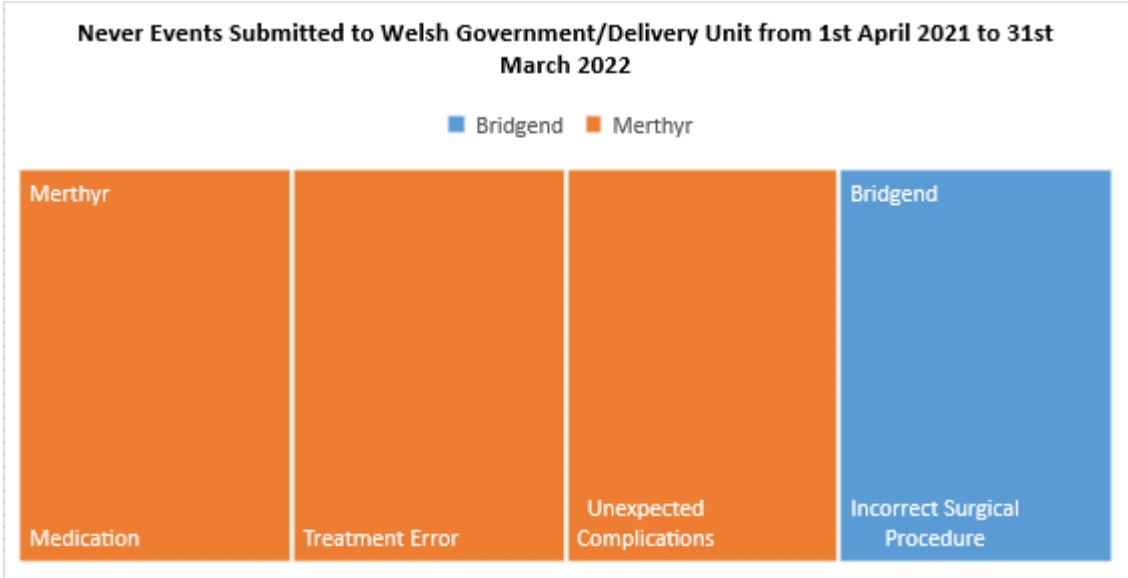


During the year, we reported 61 Serious Incidents/Nationally Reportable Incidents to Welsh Government and the NHS Wales Delivery Unit. During 2020/21, Welsh Government, in recognition of the impact of the Covid-19 pandemic, amended the guidance for reporting of serious incidents. Therefore, a comparison to previous years reporting cannot be made as to whether incident numbers have increased or decreased. Whilst there was a reduction in external reporting, the management of serious incidents within the Health Board did not change and all incidents have, or are undergoing, a proportionate investigation to identify any learning and improvement from the incident.





Three Never Events were reported in Merthyr and Cynon Locality, 1 was reported in Bridgend Locality. A breakdown can be seen below:



In early 2021, the NHS Delivery Unit announced that incident management and escalation across Wales would be changing. The new National Patient Safety Incident Reporting Policy was introduced and effective from June 14, 2021.

Whilst the policy sets out new ways of incident management, and outlines criteria for reporting, internal reporting and monitoring has required local development. The Health Board has developed mechanisms for the monitoring and reporting of incidents across all levels of harm. This has resulted in the introduction of a Locally Reportable Incident (LRI) reporting mechanism. LRIs incorporate all incidents that would have previously fallen under the category of a Serious Incident (SI) under the Putting Things Right Regulations, but no longer meet the criteria of an NRI.

This enables effective oversight and facilitates the identification of themes and trends to enable wider health board learning with a focus on improving patient safety and experience. In the latest national task and finish group to review the policy implementation, other health boards in Wales raised this element as a risk and the Health Board were commended on the introduction of the LRI monitoring process.

Over the year Root Cause Analysis investigation training has been delivered virtually to over 80 colleagues across varying specialities, although the availability of colleagues to deliver training and attend sessions has been impacted upon by the pandemic. The Health Board has invested in a robust training package and now offer and facilitate this through ESR to ensure investigations are led by trained individuals, is consistent and of high quality. All investigations are independently quality assured prior to submission for executive sign off.

The systems and processes have proven to be robust and effective and are now operating effectively. The early part of the next year will see these processes transition into the new 'Once for Wales' Datix system as this replaces the existing Datix programme. The roll out of Once for Wales will also see the introduction of the new

Action Plan module which will enable a more detailed and robust arrangement for developing, implementing and monitoring actions to ensure effective learning across all clinical service groups.

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 4 never events between 1st April 2021 and 31st March 2022, these were in relation to:

- Incorrect siting of endotracheal tube during elective emergency intubation in the setting of pulmonary thromboembolism.
- Following Routine Post-Operative care after a Caesarean birth, 3 swabs were found within the vagina.
- Patient given oramorph 10mgs in a syringe, midwife turned around and on looking back patient put syringe into own venflon and injected it.
- Patient consented and marked for RIGHT cataract surgery. Patient given peribulbar block into the LEFT eye by anaesthetist by mistake.

10.0 Peoples Experience

People's experience is a key component of a patient's journey through our primary & secondary care settings. It enables the Health Board has a number of opportunities available in order to support our patient's/families/carers and staff to ensure everyone's voice is heard and informs how we can improve upon the services we provide to our communities.

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. The Health Board's PALS teams (Patient Advice Liaison Service) also continued to support patient feedback across the acute sites and contribute to engagement sessions. Whilst also continuing to signpost to third sector stakeholders and assisting patients/families with queries across the Health Board's acute sites.

The department has also continued to explore different avenues to ensure the people's voice is heard within various specialties they manage across the Health Board. Chaplaincy services have maintained a presence on the wards providing spiritual and pastoral care to patients and families. This is also whilst supporting the ITU Bereavement Team to ensure the service could provide extended spiritual and pastoral care to families in their time of need. The Chaplaincy service have supported over 4,000 patients, families and staff throughout the year.

Our bereavement services have had to change how they operate in light of the Covid 19 pandemic and the Health Board is developing pathways and frameworks in line with the All Wales Care of the Bereaved Standards This includes providing information packs, support and signposting to relevant available services.

The Health Board's carers co-ordinator has linked in with staff across a number of different specialties to provide carers awareness training and continues to highlight the difficulties carers experience and provide support/signpost where appropriate. Carers champions are being introduced across CTM HB to ensure that carers of patients receive the appropriate guidance and support they may require.

Our volunteers have proved to be an invaluable support to the Heath Board providing a meet and greet service for our communities when attending vaccination centers for their covid vaccinations. The service itself had to change in the way it provided support due to the pandemic and as such many volunteers joined befriending helplines, pharmacy/food deliveries within the community and IT support for some digital services within the Health Board to enable patients to access on line appointments/support.

The Health Board continues to link in with third sector stakeholders and colleagues to ensure armed service personnel are supported via the Armed Forces Covenant and raised awareness of this throughout the Health Board.

People's experience is a key element to ensure delivery of quality of care alongside providing clinical excellence. The Health Board continues to strive to engage with our communities to build upon the services we provide and ensure they remain at the heart of all we do.

CIVICA

The Health Board has continued to implement the Civica system to support the capturing and monitoring of service user feedback.

Throughout 2021/2022 the maternity survey, which involves an automated text message being sent to women at 4 key points throughout the pregnancy pathway, was embedded. Linked to this, within the stage 3 labour survey, women can enter their birthing partner's details, which triggers a text message requesting feedback on their experience. This actively pushes the survey out which improves engagement in feedback mechanisms, enabling real time feedback in relation to maternity services to be received and early identification of learning.

The aim is to send an SMS text containing a survey link to all patients/service users following their contact with the Health Board. There is slippage in the timescale in delivery of this objective, due to the availability of dedicated information resource. However a number of other mechanisms within the Civica system have been used to capture service user feedback.

In January 2022, the Health Board launched the electronic "Have your Say" and Generic Patient Experience Survey. Posters containing QR codes are displayed on notice boards in our hospital sites, KHHP and Dewi Sant. In addition, links are available on our internal and external webpages, along promotion on available social media channels.

A small card (like a business card) containing a QR code has been developed which will displayed in main thoroughfares such as Emergency Departments, Outpatients and community settings. They will be made available to staff that are providing services in patients' homes. Exploration is taking place as to how the posters/cards can be promoted within he wider non-health board community settings.

From the 28.02.22, within the Bridgend and Merthyr & Cynon Localities, the PALS team are actively engaging with patients/ service users to promote the completion of the "have your say" cards and the generic survey. This is through paper copies being available in areas, which are collated and uploaded on to the system on a monthly basis. Along side this, within Merthyr & Cynon PALS Officers have been present with Emergency Department at PCH and outpatients at YCC to capture feedback via iPADS.

There are currently 18 surveys active within the system and further service specific surveys are being developed which will be implemented in the same format at the current time.

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	279
Rhondda & Taf Locality	362
Bridgend Locality	266
Corporate Function / Operations	22
Total	**929**

We received the most compliments in relation to Royal Glamorgan Hospital.

Top 5 Sites for Compliments	Total
Royal Glamorgan Hospital	309
Prince Charles Hospital	264
Princess of Wales Hospital	236
Y Bwythyn	16
Tonteg Site	15

11.0 Learning

The Health Board is committed to promoting a culture which values and facilitates learning and in which the lessons learned are used to improve the quality of patient care, safety and experience. A Listening & Learning framework has been developed and demonstrates how learning will be identified, disseminated and implemented in practice, in order to facilitate and embed a culture of appreciative enquiry and continually improving health care services.

This framework is supported by a Shared Listening and Learning Forum which provides 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'.

Learning from Events Reports (LFERs) following a concern which resulted in a Redress or Claims case is a key mechanism used to capture learning. These focus on capturing identified key learning and how improvements are implemented, shared and embedded across the organisation, ensuring closing of the learning loop. These are scrutinised by an external Welsh Risk Pool panel in order to gain assurance that learning has been effectively undertaken and shared before reimbursement for costs incurred are processed.

A considerable amount of work has been undertaken to assist clinical teams in completing the LFER effectively and capture and disseminate learning across the organisation.

To further support the process of completion of LFERs, a 'How to Guide' and 'Standard Operating Procedure' were developed and shared across the Health Board. Training took place via planned sessions with key specialities, in addition a number of drop in training sessions took place, allowing staff to raise specific issues.

12.0 Looking Forward – Priorities for 2022/23

The people, who use our services, wherever they live, should expect no variation in approach to care and resources within our health board. To provide a consistent, equitable function across the Health Board in respect of Quality Governance, Patient Safety, People's Experience and Putting Things Right, the current ILG Quality Governance roles and responsibilities are being re-aligned in order to provide a centrally managed team structure with a focus on effectiveness, performance and equitable distribution amongst the proposed care groups. The centralisation of the functions will provide greater flexibility and mobilisation to services where greater support is required in order to respond to acuity fluctuations and need.

The model will also support a central cohort of professional and technical expertise to support our services in responding to complex issues. The services within the '**Quality Governance Central Team'** will work hand in glove with the Care Groups and Clinical Service Groups to ensure a quality service from the outset, but when things do go wrong, lessons are learnt and acted on swiftly and our patients and families are supported appropriately.

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.

As we move forward into 2022, our priorities will be to:

- Implement and embed a new structure to support the new operating model, with a key focus on quality, safety and learning, which will be supported by our new and revised frameworks and policies;
- Build on the initial success of the pilot complaints triage process, continuing to work closely with our patients and the public to resolve issues at the earliest stage, which should see an increase in early resolutions and a decrease in formal complaints;
- Further build and strengthen learning from events by implementing our Learning Framework and monitoring ourselves against it;
- Host our first virtual Learning from Events Day, sharing lessons from incidents, complaints and claims, as well as showcasing good practice; and
- Implement any changes required in relation to the Health and Social Care (Quality and Engagement) (Wales) Act, in particular Duty of Candour.