
# Putting Things Right Annual Report 2020 - 2021

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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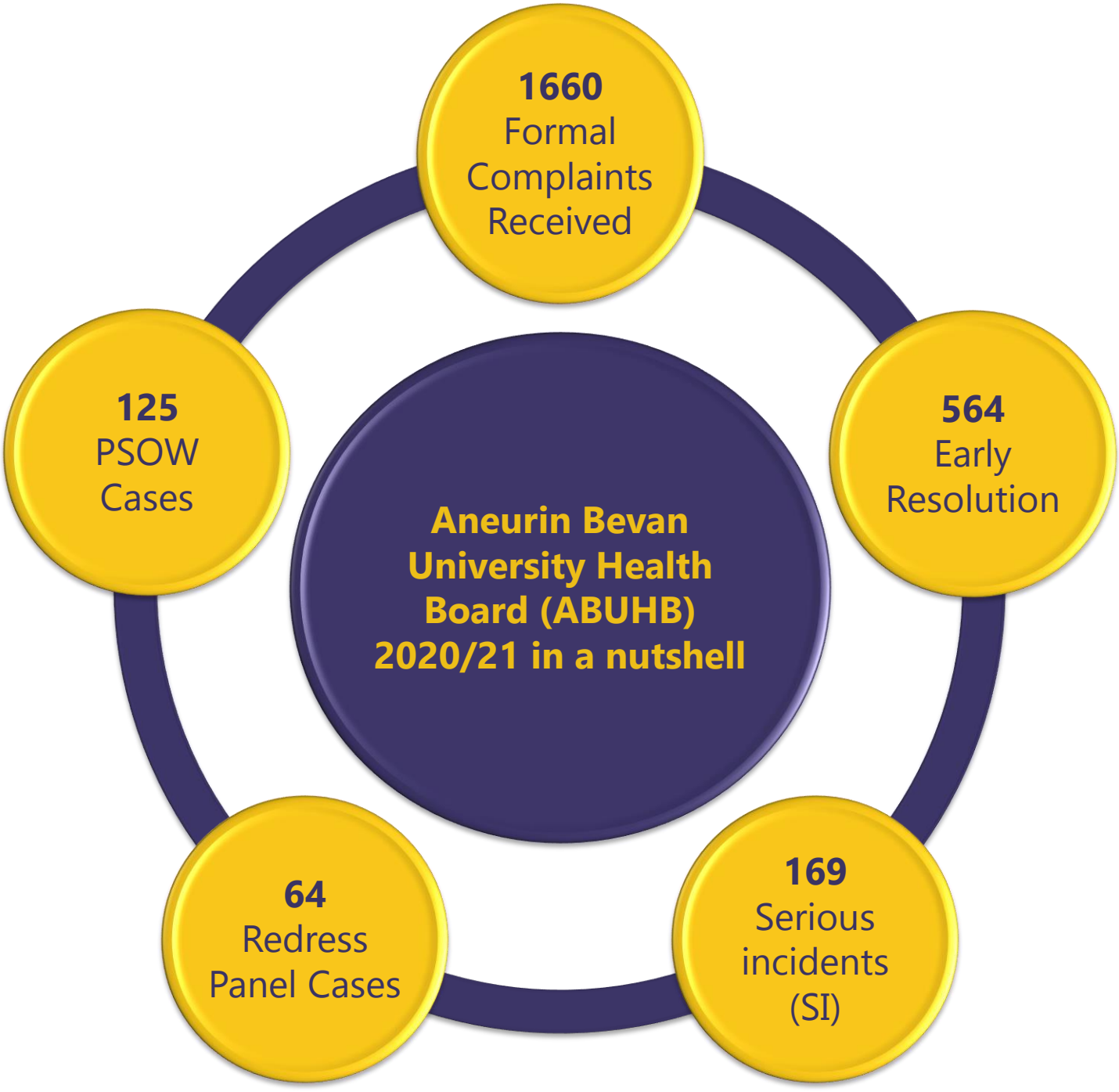
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2020/21 in a nutshell

# Introduction

There are a number of policy and strategic drivers influencing the Putting Things Right agenda across NHS Wales. There is compliance with legislation and guidance to deal with concerns, incidents, near misses and claims as set out in the "Putting Things Right" (PTR) arrangements, as outlined in this Annual Report.

To support the implementation of *'Putting Things Right'* during the time of Coronavirus (Covid-19), Welsh Government (WG) issued guidance in March 2020. The guidance set out that the Health Board should continue to adhere to the National Health Service (Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 for the *"Putting Things Right"* process where possible, however it recognised the need to curtail corporate business and consider how best to manage PTR processes.

During the pandemic the Health Board used a "proportionate approach" to ensure, where possible, rapid handling of concerns/complaints/serious incidents and de-escalation where possible. The PTR team worked closely with Divisions and Legal Services to support this approach, to ensure organisational responsiveness in line with PTR Regulations. The changes primarily focussed on any investigations being proportionate, reinforcing the importance of honest communication with people raising concerns, whilst managing expectations.

The Annual Report is underpinned by Health and Care Standard 6.3, Listening and Learning from Feedback. People who receive care, and their families, must be empowered to describe their experiences to those who provided their care. This will ensure there is a clear understanding of what is working well and what is not. Additionally, they must receive an open and honest response.

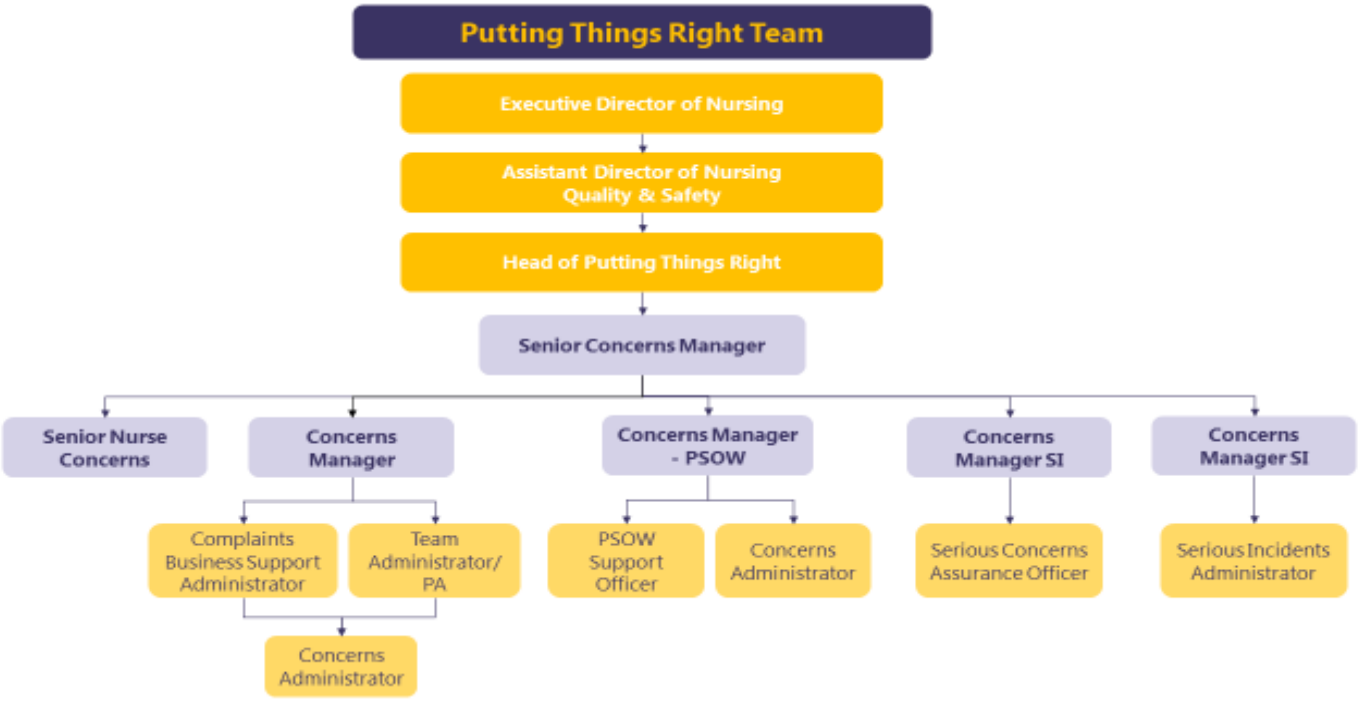
Health services are expected to be shaped by, and meet the needs of the people served, and demonstrate that they act on and learn from feedback.

When concerns are raised about treatment and care, the focus is centred upon responding to these in a candid, open, honest and timely manner. The emphasis is placed upon undertaking a comprehensive review, drawing together themes, identifying areas for improvement, and promoting learning to enhance patient experience and improve services moving forward. Concerns will receive a thorough, appropriate and proportionate investigation, a prompt acknowledgement setting out how the matter will be managed, in line with the underlying principle of Putting Things Right.

Aneurin Bevan University Health Board (ABUHB) promotes a culture that encourages staff to raise concerns and offer suggestions, challenge current practice without fear of blame or repercussions, promote belonging as part of a team and learn together. Throughout the Covid-19 pandemic, both services and staff have been impacted. A number of changes to the way in which services have had to operate has meant that the planned improvements identified in 2019/20 have, in some areas, been impacted, specifically the development of a learning framework and the introduction of the OfWCMS.

## Governance Structure

The Chief Executive has overall accountability for "Putting Things Right" with executive leadership delegated to the Director of Nursing. Assurance is provided by exception reporting to the Quality, Patient Safety Operational Group, along with the Patient Quality Safety and Outcomes Committee.




## How did we do against 2019/20 goals?

The PTR Annual Report for 2019/20 set out a series of objectives for 2020/21. Table 1 provides a summary of the progress made against these.

**Table 1: Summary of Progress**

| Priorities for 2020/21 | How did we do? |
|---|---|
| Improvement in the timeliness of responses to complaints. | ▪ **Increase** from 63.5% to 69% compliance. |
| Taking forward further training in both concern and serious incident investigations. | ▪ A suite of training events have been implemented. |
| Improvement in the quality of complaint responses. | ▪ There has been a reduction in the number of investigations that upheld complaints about poor complaint handling, demonstrating an improvement in this area. |

| Priorities for 2020/21 | How did we do? |
|---|---|
| Further development of the Learning Framework with an emphasis on learning and continuous improvement. | ▪ Not achieved due to staff deployment. |
| Newsletter to be introduced in order to share and promote good practice. | ▪ Not achieved due to staff deployment. |
| Complaints Co-ordinator Forum to be established as a support network. | ▪ Complete – meetings ongoing. |
| More robust trend analysis of complaints/ incidents to inform areas for learning and development. | ▪ Analysis is improving and is reported to Divisions, QPOSG and PQSOC |
| The improved use of Datix through the 'Once for Wales Concerns Management System Programme (OfWCMS), developing a consistent approach in the use of Datix across all Health Boards. | ▪ The national roll-out plan of the new system was delayed. OfWCMS is due to be released May 2021. |
| Further enhanced relationships with PSOW and officers. | ▪ Ongoing meetings and regular communications have strengthened relationships between PSOW and ABUHB. |

# Successes and Challenges

## Successes

### Education and Training

- Introduction of experienced investigator buddies for trainees for support.
- The development tools for SI's, guidance notes for report writing, completing a Welsh Government closure summary and conducting an investigation.
- Development of complaint response hints, tips and tools facilitating higher quality management and response.
- The development of response letters and a rapid response serious incident template during Covid-19.
- Implementation of Public Services Ombudsman for Wales (PSOW) hosted training for aspects of Concerns/SIs/PSOW.

### Partnership Working

- Regular meetings with the Community Health Council (CHC) that have fostered positive working relationships and strengthened lines of communication.

- Continued quarterly meetings with the PSOW Improvement Officer, forging improved relationships.
- Following a meeting in March 2020 with the Gwent Regional Coordinator for the Ethnic Youth Support Team (EYST) All Wales BAME Engagement Programme. PTR Senior Managers were invited to speak at the All Wales BAME Forum 'Your Health and Social Care Rights in Wales'.
- During the reporting period, relations have been strengthened with WAST, through regular meetings.

### Communication

- Introduction of Patient Support Information Helpline, initiated, launched and managed a seven day service.
- Co-ordination by the Corporate PTR Team, escalating directly to the clinical areas concerned, where possible, and facilitating early resolution. Through contact with key individuals, concerns have received earlier attention, thus improving response times and enhancing the experience for complainants.

### Complaint Handling

- PSOW highlighted 3 issues regarding complaint handling which is an improvement from 2019/2020, where 8 were identified. Reduction in payments awarded by PSOW in the last financial year.
- The Health Board has taken steps to improve complaint handling and have developed Investigating Officer training sessions which have been delivered. The sessions incorporate the issues raised by the PSOW's investigation and emphasised the importance of good communication, as well as the accuracy and robustness of complaint responses, and maintenance of complaint files.
- There have been fewer complaints.

## Challenges

- Repurposing of Divisions and impact on historical concerns and their management
- PTR staff deployed to support Covid effort
- Delay of launch of RLDatix and associated pressures
- Increase in use of temporary staff, with reduced awareness of ABUHB policies and processes.
- Initial suspension of training
- Direct impact of Covid-19 pandemic (elective surgery cancellations and vaccine queries etc.

# Concerns / Complaints

## What is a concern?

A concern is when a patient or member of the public feels unhappy about any service provided by the NHS. Each and every concern raised deserves, and is entitled, to receive an appropriate and proportionate investigation and response.

There have been:

**671,608**

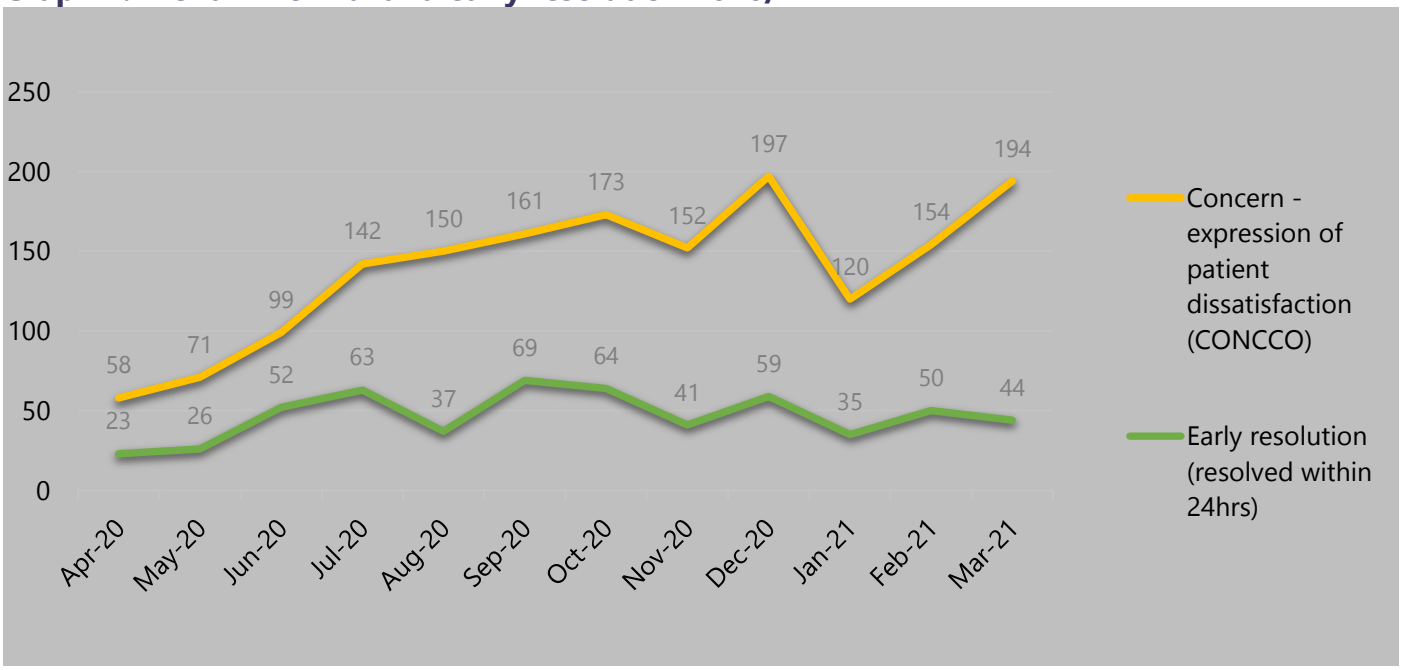
2020/2021 total patient interactions for 5 largest Divisions (admissions and outpatients)

**0.25%**

of these interactions resulted in the raising of a concern

These figures represent the impact of Covid-19 upon complaints. Interactions between the Health Board and patients (inpatient stays and outpatient appointments) were down by a third in 2020/21 from 2019/2020 (from 1,006,362 to 671,608). Of the 671,608 interactions in 2020/2021, 293,341 were 'virtual' interactions. This could partly account for the rise in communication/information concerns, and similarly for the drop in waiting times and delays as fewer patients were physically being seen. There was more demand on channels of communication as visiting had largely been curtailed (or replaced by visiting with a purpose) during the reporting period. Relatives had to rely on other means of communication.

**Graph 1: Trend in formal and early resolution 2020/21**



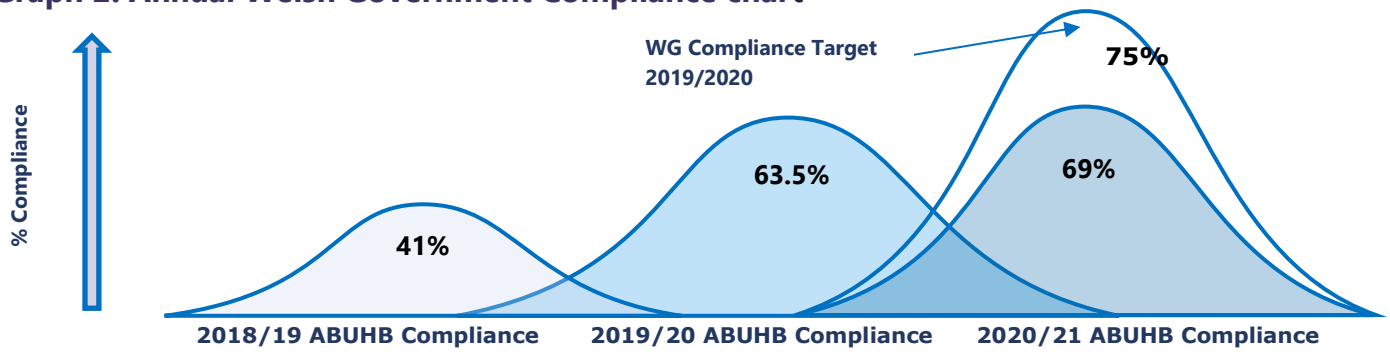

During April and May 2020 a very low number of complaints were received, coinciding with the Covid-19 pandemic. December 2020 and March 2021 saw a spike in the number of complaints received, primarily at the Grange University and Royal Gwent hospital sites. The main themes were communication and clinical care.

During March an emerging theme was identified in relation to further issues / delays with elective procedures. There was also a theme identified during Quarter 4 relating to vaccination queries.

## Compliance with Welsh Government Targets

In 2020/21, the Health Board received 2224 complaints, 564 were resolved under early resolution. 2138 complaints were closed in year, of which 1475 were responded to within 30 working days, the Welsh Government target. Overall compliance for the year = 69% as illustrated in Graph 2. Whilst the target is still not being achieved there has been a year on year increase in performance and significant increase from 2018 to 2021.

### Graph 2: Annual Welsh Government Compliance chart

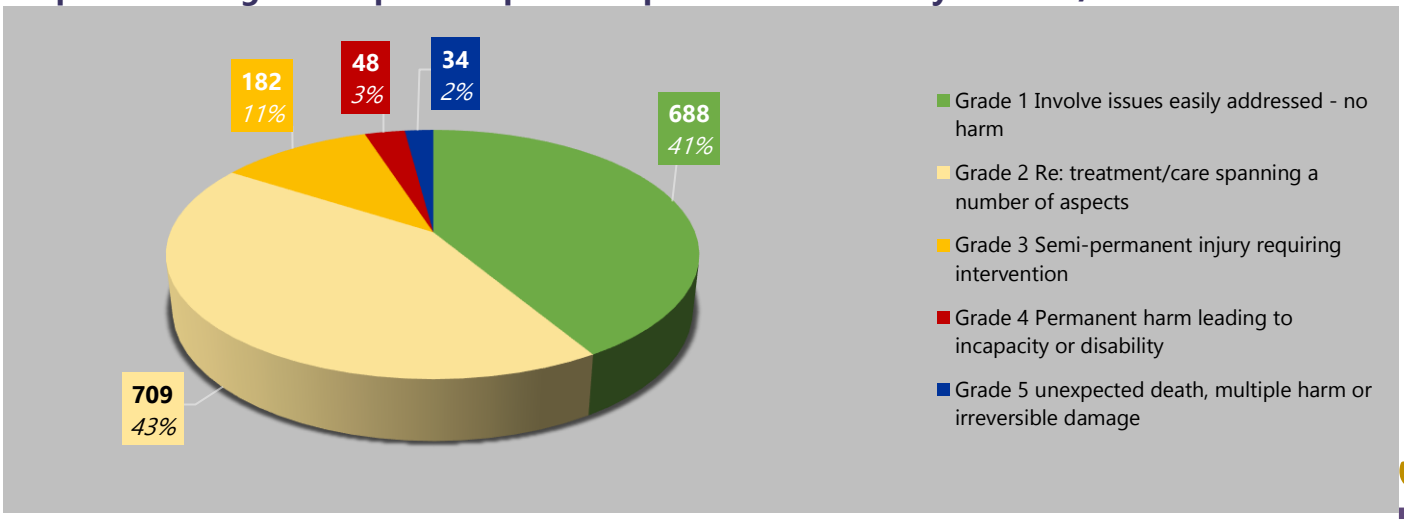



The following graph shows grading of complaints, based on national definition.

### Table 2: Guidance of Grading the Level or Harm in Complaints

| | |
|---|---|
| **Grade 1** *No Harm* | No harm. |
| **Grade 2** *Low Harm* | Minor implications for patient safety, patient fall requiring treatment, minor treatment. |
| **Grade 3** *Moderate Harm* | Semi-permanent injury or impairment of health or damage requiring intervention, re-admission, additional interventions. |
| **Grade 4** *Severe Harm* | Semi-permanent harm leading to incapacity or disability, additional interventions, increased stay >15 days. |
| **Grade 5** *Catastrophic Harm* | Unexpected death, multiple harm or irreversible health effects, avoidable loss of life. |

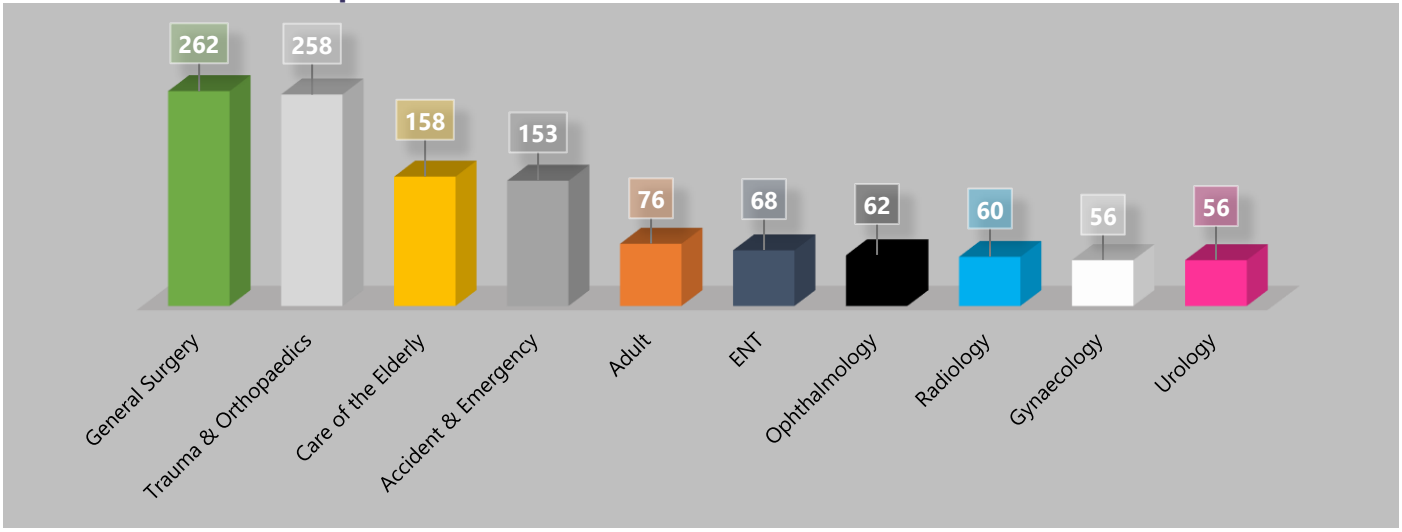
### Graph 3: Grading of complaints upon receipt for the financial year 2020/21



As can been seen the majority of concerns **(84%)** are graded low or no harm, with grade 4/5 = 5%.

The following graph outlines complaints by specialty, with Surgery and Trauma and Orthopaedics receiving the highest number.

**Graph 4: Specialties receiving the highest number of formal complaints in the financial year 2020/21 (Top 10)**




## Improving the timeliness and quality of complaint responses

There has been an organisational focus on improving the quality of responses and turnaround time, albeit Covid-19 has hampered this work. Training has been conducted for key stakeholders with widespread attendance and positive feedback.

There has been a continual drive towards enhanced networking between PTR, Divisions, Call Centre Management Centre and Booking Teams. This included setting up a Complaints Co-ordinators Network Meeting and a more proactive approach from PTR in dealing with corporate complaints, which included the introduction of a tracking system.

## Learning from Complaints

### Availability of Wi-Fi for long stay patients in Mental Health Inpatient settings

The Community Health Council (CHC) conducted virtual 'chats' with patients at St Cadoc's as part of their ongoing monitoring arrangements. Patients told the CHC that the lack of Wi-Fi was impacting their stay – particularly during the pandemic. The Health Board has now installed Wi-Fi in all patient areas in St Cadoc's.

## Learning during Covid-19 Pandemic

- Some complaints were raised by patients who were exempt from wearing face coverings. The Health Board embarked upon a campaign aimed at raising awareness amongst staff and the general public around face covering exemptions. This resulted in the production and sharing of guidelines in hospital areas and GP surgeries.
- In response to the pressures brought about by the Covid-19 pandemic, ABUHB introduced a new system for logging and tracking patient possessions, as patient movements between wards and hospitals increased. This was coordinated through the Bereavement Service.
- As a response to an increasing number of complaints from the public with regards to contacting patients or wards and departments, a central bespoke telephony service was introduced on all sites from January 2021. Staff were based at GUH, NHH and RGH, but covered all hospitals, acting as a link between the caller and the ward. This was a 12 hour, 7/7 service which evaluated positively and was temporarily extended as a result (the service ceased in June 2021).

## Learning Disability patient in Acute Care

- As a result of a patient related concern from a young woman with physical disabilities attending hospital, who had experienced a failure to meet her physical needs whilst in hospital, she refused to be admitted again. This risked a potential detriment to her future health. This resulted in the development of a bespoke care plan with the Health Board and the young woman to address her complex manual handling needs whilst in hospital.

## Improving communication in Community Hospitals

- In response to a complaint raised regarding communicating updates and treatment plans with families, a number of actions were implemented: -
  - All community wards introduced a communication diary where all requests for telephone calls are recorded on the day they are requested.
  - The ward doctors and clinical leads check the communication diary daily to ensure they are aware of all contact requests and respond to these in a timely manner.
  - Carer Clinics are to be reintroduced. These clinic sessions provide an important platform for relatives / next of kin to schedule appointment with the ward doctors and nurses to discuss the current and future care plans for their relatives and future expectations.

# Public Service Ombudsman for Wales (PSOW)

The number of complaints referred to PSOW provides a marker of the way in which the Health Board has responded to the complaints received. Our aim is to always deal with complaints in a timely, fair and robust manner and, where possible, address all issues raised at a local level. There are times when complainants remain unhappy with the response they have received and will refer their complaint to the PSOW.

The Covid-19 pandemic has understandably had an impact on the Ombudsman's service and this is evident from the number of complaints they have received this year, and the way in which the Ombudsman's staff have had to work. PSOW recognised the pressure the Health Board has been experiencing, liaising with the PTR team before issuing complaints to ensure the Health Board had the capacity to be able to accept them. Deadlines have been extended, where necessary.

During 2020/21, quarterly meetings have been held with the PSOW Improvement Officer. Therapeutic working relationships have been maintained and efficient processes in place to ensure, where possible, deadlines are met.

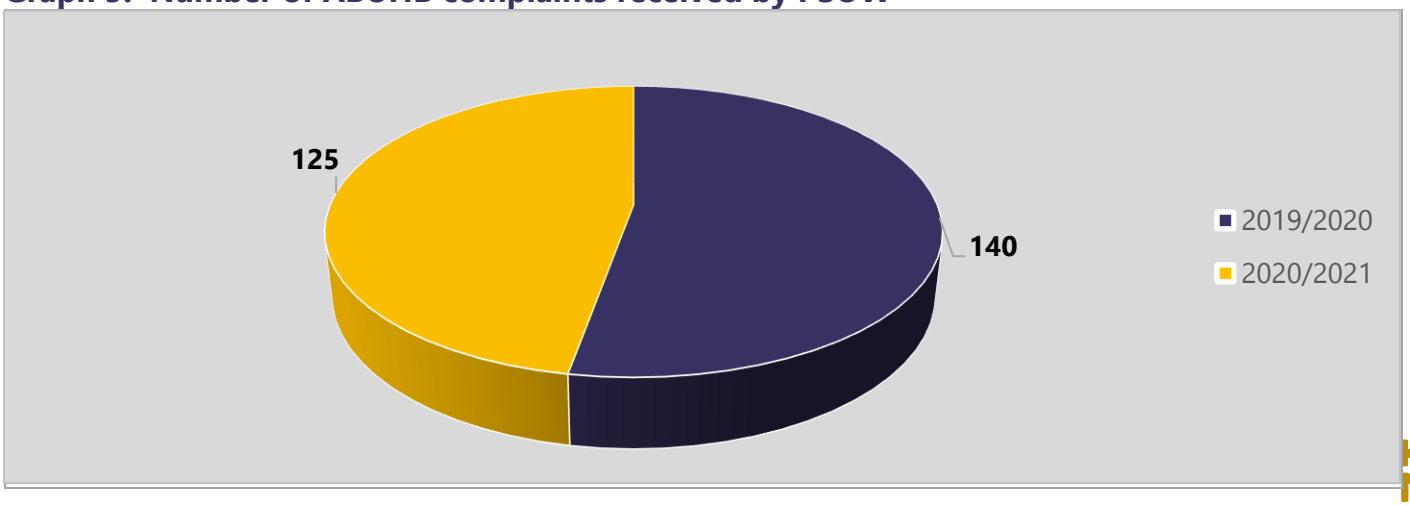
The Health Board received a final Public Interest Report regarding a delay in diagnosing cancer which resulted in the patient undergoing unnecessary procedure which led him to suffer debilitating side effects, affecting his quality of life. All necessary actions were taken on receipt of the final report and an action plan was developed to ensure all recommendations were completed, with the final recommendations due to be completed in July 2021.

## Number of complaints received by PSOW

During 2020/21, the PSOW received 125 complaints, of which 29 were enquiries. There were 96 total number of complaints for ABUHB they dealt with.

As expected, the Covid-19 pandemic impacted upon the number of complaints the PSOW received in 2020/21. The following graph shows the number of complaints received by the PSOW over the last two years, showing a decrease.

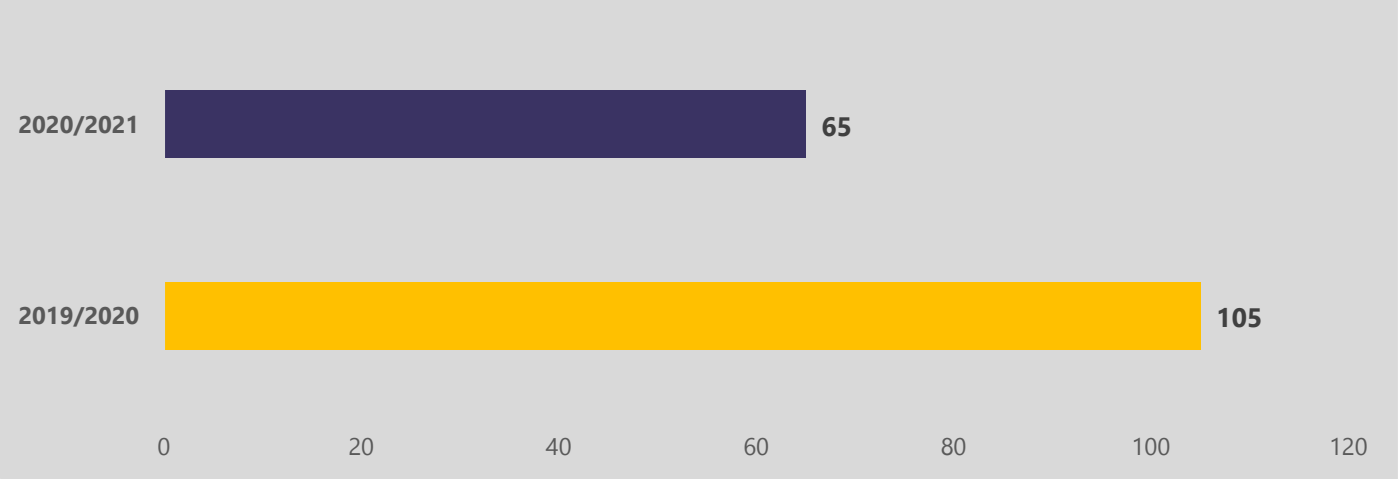
**Graph 5: Number of ABUHB complaints received by PSOW**



A proportion of the complaints that the PSOW received would have either been rejected at the outset or would have remained anonymous and therefore would not have been recorded by the Health Board. This means that the number of complaints received by the PSOW differs from the number accounted for by the Health Board.

A total of 65 new complaints were received from the PSOW this year, which is significantly fewer than last year.

**Graph 6: Number of complaints received from PSOW**

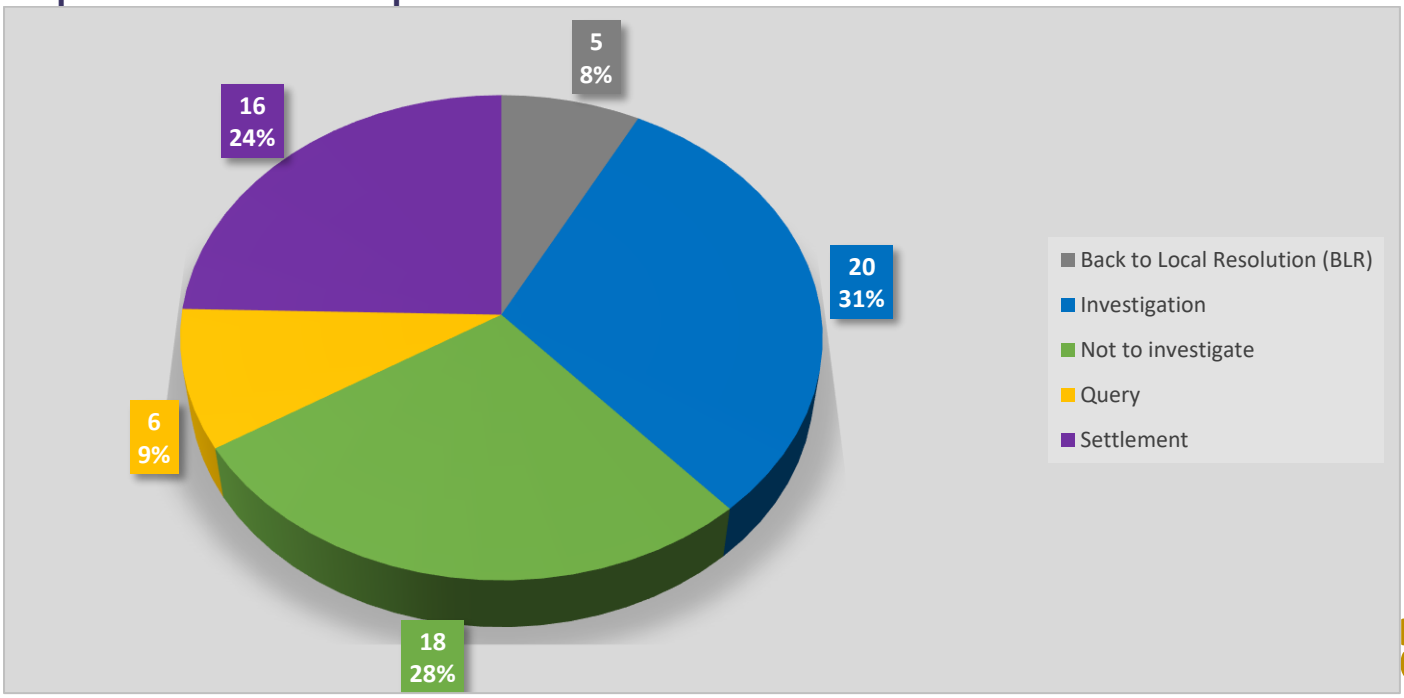



Of the 65 complaints which were referred back to the Health Board for further improvement, 21 were complaints that the Health Board had initially received in 2020/21, 36 were complaints from 2019/20 and 8 were from 2018/19.

## Outcome of complaints received by Health Board from the PSOW

The outcome of the 65 PSOW complaints received in 2020/21 is presented in graph 7.

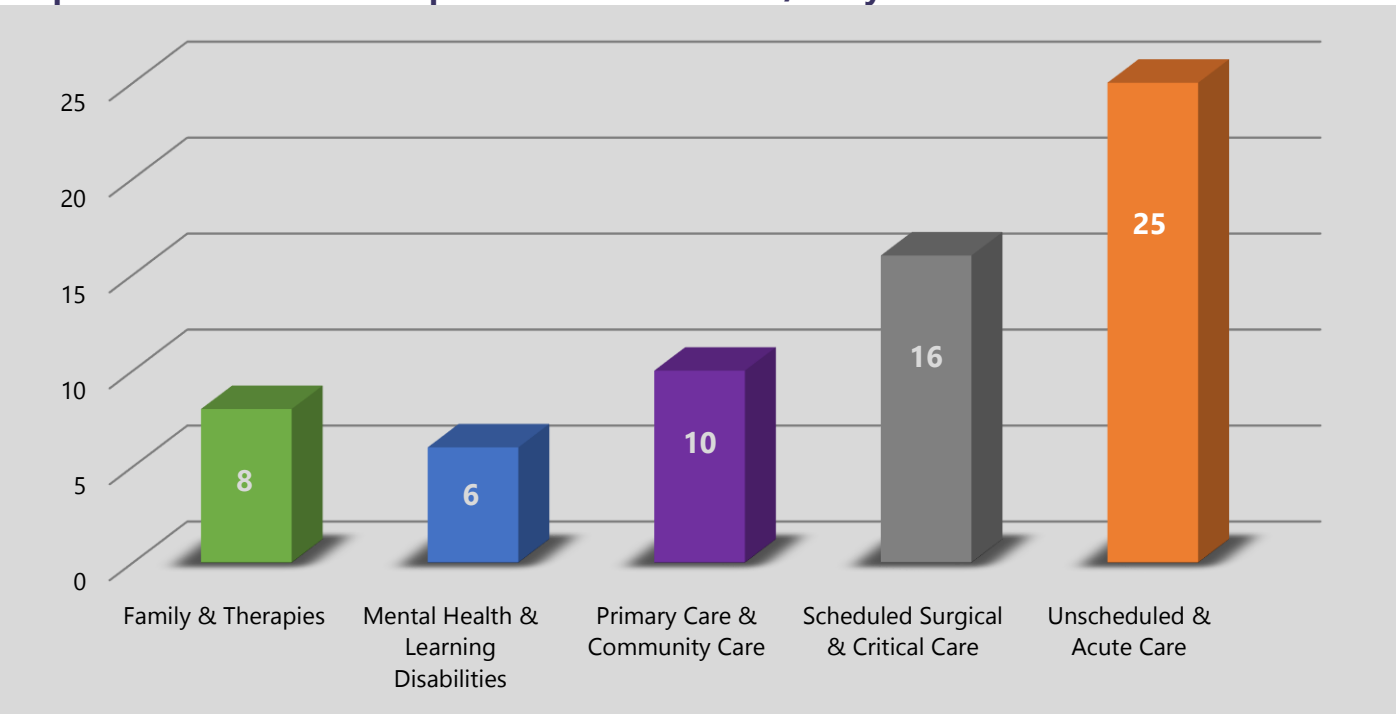
**Graph 7: Outcome of complaints received from PSOW**



20 complaints received last year went on to require a full PSOW investigation which, at the time of reporting, are at different stages of completion.

A breakdown of the complaints received by Division is shown in Graph 8.

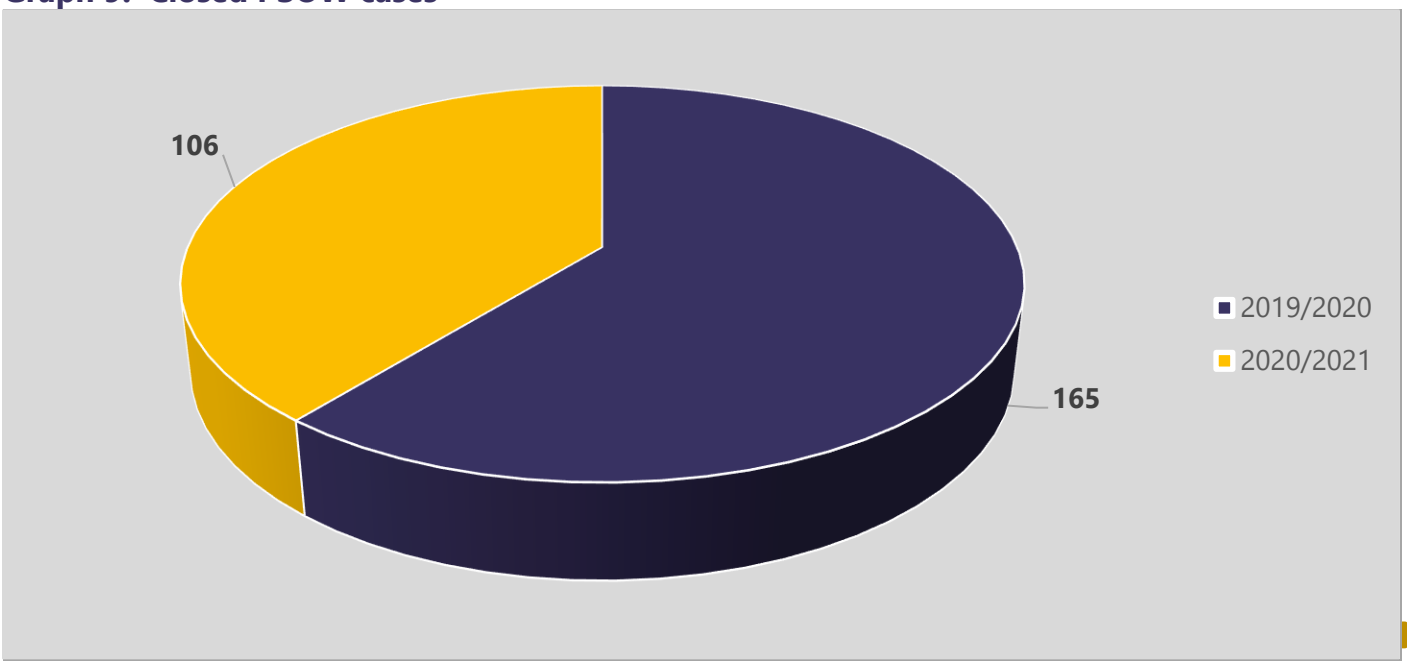
**Graph 8: Breakdown of complaints received in 2020/21 by Division**




## Complaints closed by PSOW

As shown in the following graph, there has been a decrease in the number of complaints the PSOW closed in 2020/21.

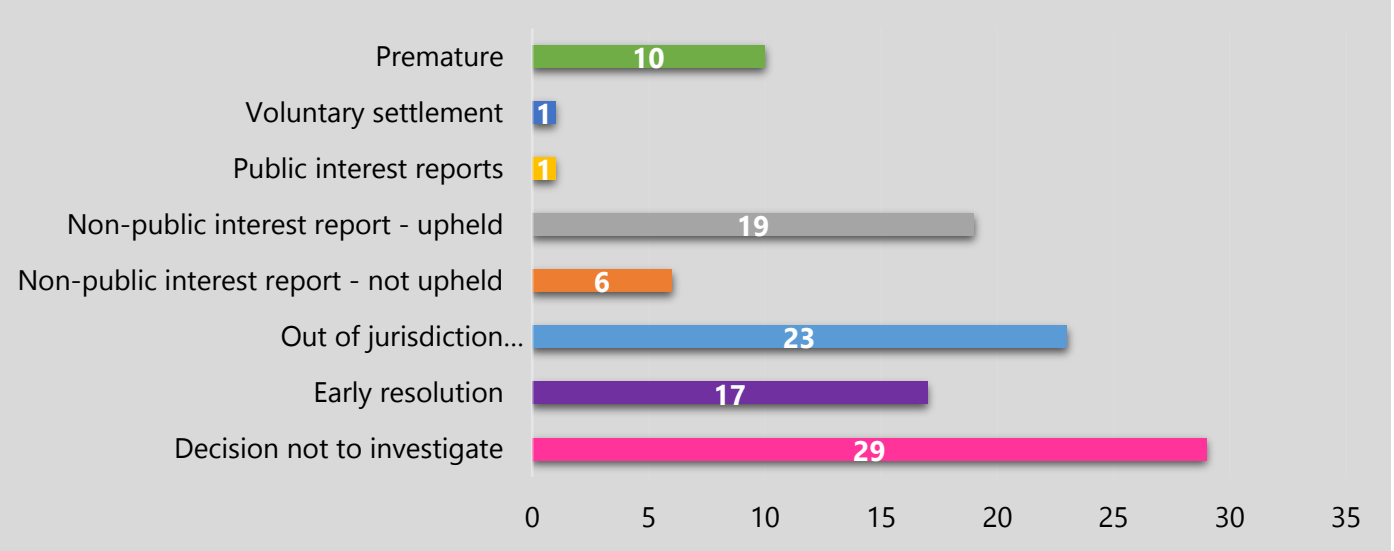
**Graph 9: Closed PSOW cases**



The intervention rate for 2020/21 i.e. where there has been an investigation, early resolution or settlement, was 36%, indicating a slight rise of 3% compared with 2019/20. 17% of these cases were resolved by early resolution.

The outcome of complaints closed by PSOW is shown in Graph 10.

**Graph 10: Outcome of complaints closed by PSOW**

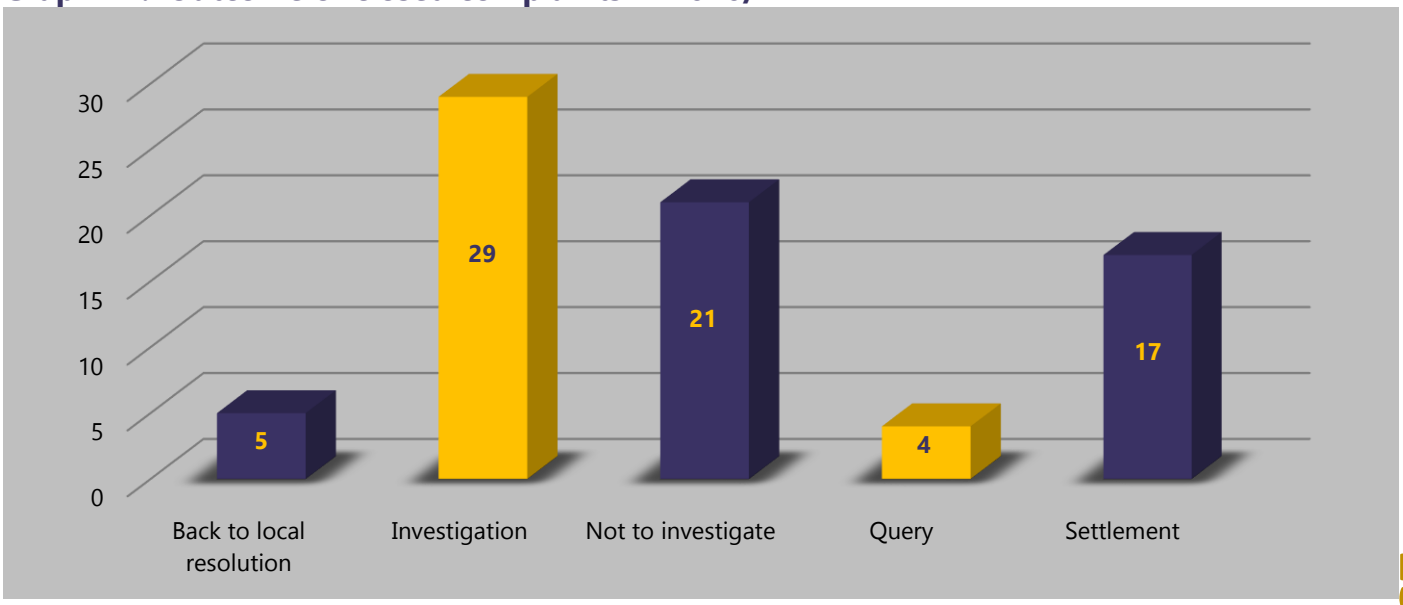



The PSOW closed 106 cases in 2020/21 and the Health Board closed 76 PSOW cases. The difference of 28 can be attributed to complaints closed by PSOW that the Health Board would have no knowledge of.

The 76 closed cases include complaints received by the Health Board in previous financial years, not only complaints received in 2020/21.

## Outcome of PSOW complaints closed by the Health Board during 2020/21

**Graph 11: Outcome of closed complaints in 2020/21**

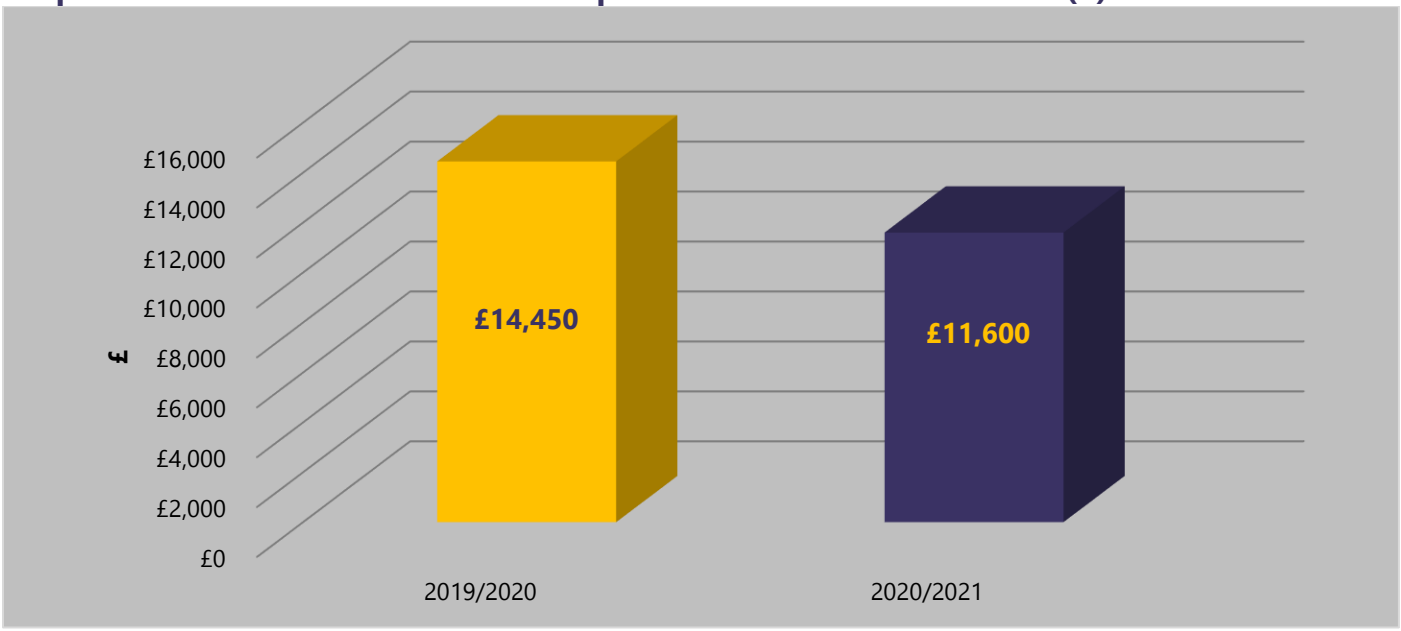


As shown above, out of the 76 closed cases, 29 were PSOW investigations. 22 of these were upheld, 6 were not upheld and 1 was inconclusive.

## PSOW financial settlements

Where the PSOW considers there has been an injustice they are able to recommend a financial payment. This can be at any stage i.e. as a settlement or as part of the recommendations following a full investigation. The following information shows the financial amount paid out by the Health Board at the request of the PSOW over the last two years, indicating a slight reduction in payments in 2020/21.

**Graph 12: Total amount awarded at request of PSOW for cases closed (£)**




## Examples of Learning from PSOW Cases

### Discharge Planning

An investigation identified shortcomings in discharge planning for a patient, who died at home, on his own, shortly after being discharged.

Work has been undertaken across all Divisions to include:-

- Audits are undertaken that focus on the completion of key nursing documentation.
- A new One Patient One Day audit tool has been introduced across all wards. It is a far more comprehensive audit tool that requires remedial action to take place if the relevant documentation has not been completed.
- Admission and discharge processes are reviewed to find ways of safely improving the patient's journey/experience.
- A Discharge Checklist and Discharge Leaflet has been produced as part of the Model Ward Roll-out Project.

## Delays in Diagnosis

Two PSOW investigations identified a delay or failure in diagnosing cancer.

The first case was in relation to a failure to take appropriate follow-up action after the patient had an X-ray in November 2017 that showed some "shadowing" but which the Health Board reported as normal. Based on the evidence, it was concluded that the Health Board should have identified the patient's lung cancer sooner and there was an unnecessary delay of 6 months between the first X-ray and the eventual diagnosis.

Since this incident, job planning has taken place with Radiologists which has increased the number of reporting sessions to reduce any build-up of reports. It has increased the number of sessions so that each reporter undertakes 7 sessions per week. Additional Radiographers and a reorganisation of the staff rotas has allowed the service to give the reporting Radiographers the time they require to report. The reporting Radiographers have also extended their scope of practice so they can now undertake GP request reporting, so easing the burden on Radiologists. In addition, two Radiographers are studying in Cardiff to enable them to undertake chest and abdomen reporting. Radiology is also linked to an external supplier and has established trigger points for reporting levels at which they will outsource any backlog for reporting to reduce any delays.

The second case, and which was the subject of the Public Interest Report, was regarding a delay in diagnosing cancer which resulted in the patient undergoing unnecessary procedure which led him to suffer debilitating side effects, affecting his quality of life.

The Health Board made a redress payment of £5,000 in recognition of the failings identified.

In addition, and as a result of this case, the Health Board has revised its mpMRI (Multi-Parametric Magnetic Resonance Imaging) Prostate Protocol and reviewed and updated the Prostate Cancer section of the Uro-Oncology MDT meetings.

The Health Board will also consider an MDT review of all prostate cases (June 2018 to present date) where subsequent pathology placed the patient into the higher risk category from a staging review, and will review its MDT procedure to consider implementing a routine audit of MRI reporting against pathology outcomes. This will be completed by July 2021.

## Diabetic Care

The Ombudsman's investigation identified an error in the Day Surgery Unit where there was a failure to administer the patient's medication for diabetes and adequately monitor their condition.

The incident highlighted the significance of health care professionals being aware of the importance of diabetic monitoring and training.

The Day Surgery Unit has introduced a link nurse for diabetes. All staff have attended training.

All registered nurses have completed the "6 Steps to Insulin Safety".

A learning event has been scheduled which coincides with Insulin Safety Week.

**Deteriorating Patient / Delay in Identifying Sepsis**

The Ombudsman investigation found that on a number of occasions hourly observations had not been completed, resulting in a delay in recognising the patient's deterioration.

As a result of the investigation, refresher training on the use of early warning systems to identify acutely ill patients and sepsis has been provided and all staff on the ward are now up-to-date.

Training has been provided with the Outreach Team relating to NEWS and frequency of observations.

There was an introduction of Treatment Escalation Plans across all sites. Nevill Hall introduced a team meeting where ITU/medical teams, including consultants discuss patients. All Treatment Escalation Plans (TEP) are discussed for every patient on site and audited. Findings include discussions with family, a record of discussion between ITU and other teams.

Treatment Escalation Plans are now a core part of any patient's medical records (for inpatients).

The NEWS JUMPCALL SEPSIS training presentation was delivered to the Senior Management Team on the Stroke Ward, with a cascade training approach.

**Complaint Handling**

The Health Board had fewer investigations in 2020/21associated with shortcomings in complaint handling. 3 highlighted issues regarding complaint handling, representing an improvement from 2019/20, where 8 cases had been identified.

The Health Board has taken steps to improve complaint handling and have developed Investigating Officer training sessions, which have been delivered. The sessions incorporate the issues raised by the PSOW's investigation and emphasises the importance of good communication, as well as the accuracy and robustness of complaint responses.

# Redress

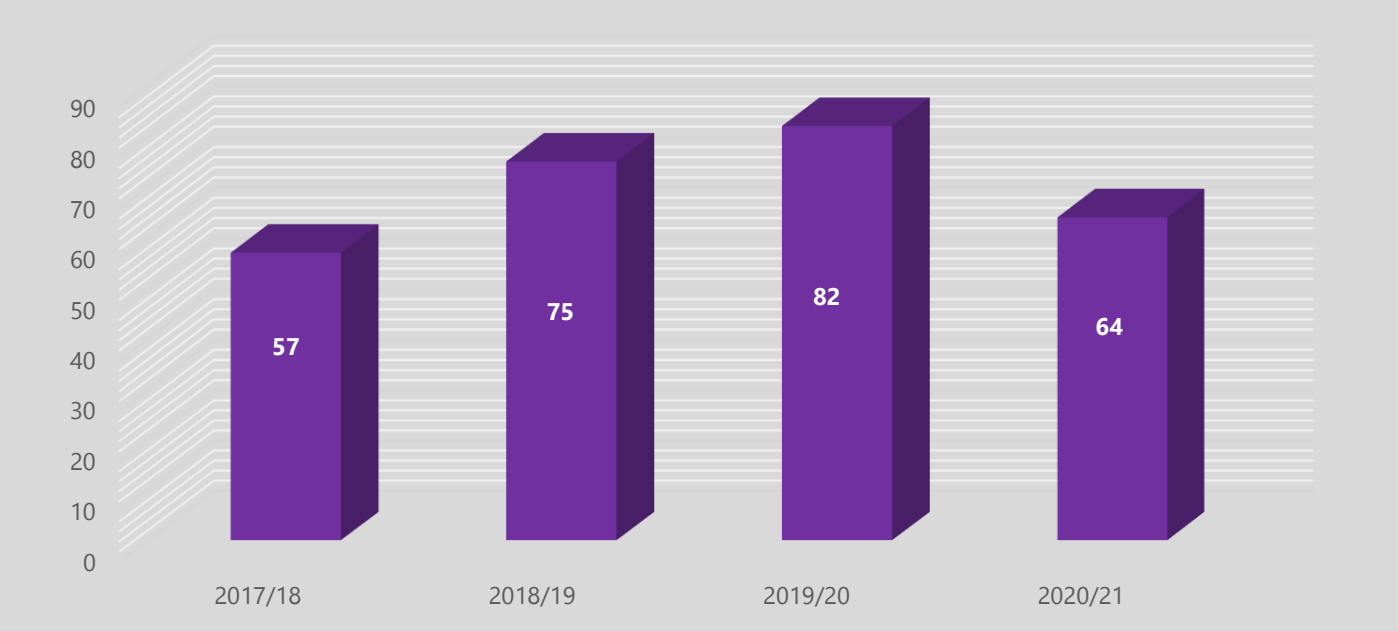
Under the framework for investigating concerns, including patient safety incidents, there is an obligation on the Health Board, where harm has occurred or is alleged to have occurred, to consider whether there is a qualifying liability in tort i.e. are there failings in care which amount to a breach of duty of care and has that breach of duty led to the harm suffered or materially contributed to it. The test of a breach of duty of care is the same as the legal test and is based on the Bolam principles i.e. were the decisions and actions taken reasonable and appropriate as judged by a body of peers?

The Health Board has a well-established Redress Panel to make the determinations in those cases where it feels there have been failings and the failings may have led to harm. Cases are heard every three weeks. Whilst making determinations as to whether a qualifying liability exists, there is also a

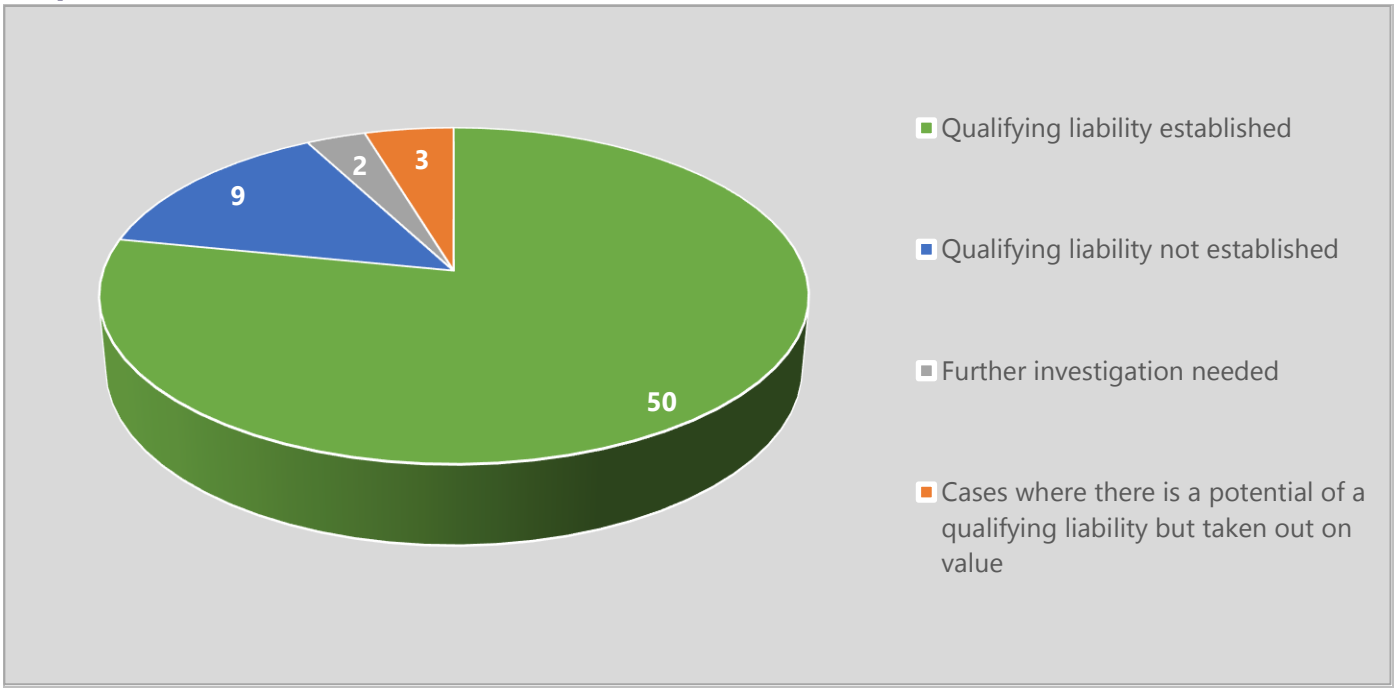
strong emphasis on ensuring that learning has taken place that is robust and has been shared as widely as possible. Areas of good practice are also highlighted and shared.

Redress Panel, like many other activities, was affected by the Covid-19 pandemic and was suspended from April to August 2020. In addition, Panel was cancelled in January and February 2021, during the "second wave". When Panel did resume, in between these periods, it was done virtually/remotely with cases being presented to Panel by the Legal Service Manager. Prior to the Panel, cases are scrutinised by the Legal Services Team to ensure that the Panel have all the requisite information to enable them to make their decisions. Despite being suspended for a number of months, 64 cases were presented to Panel, fewer than the previous two years.

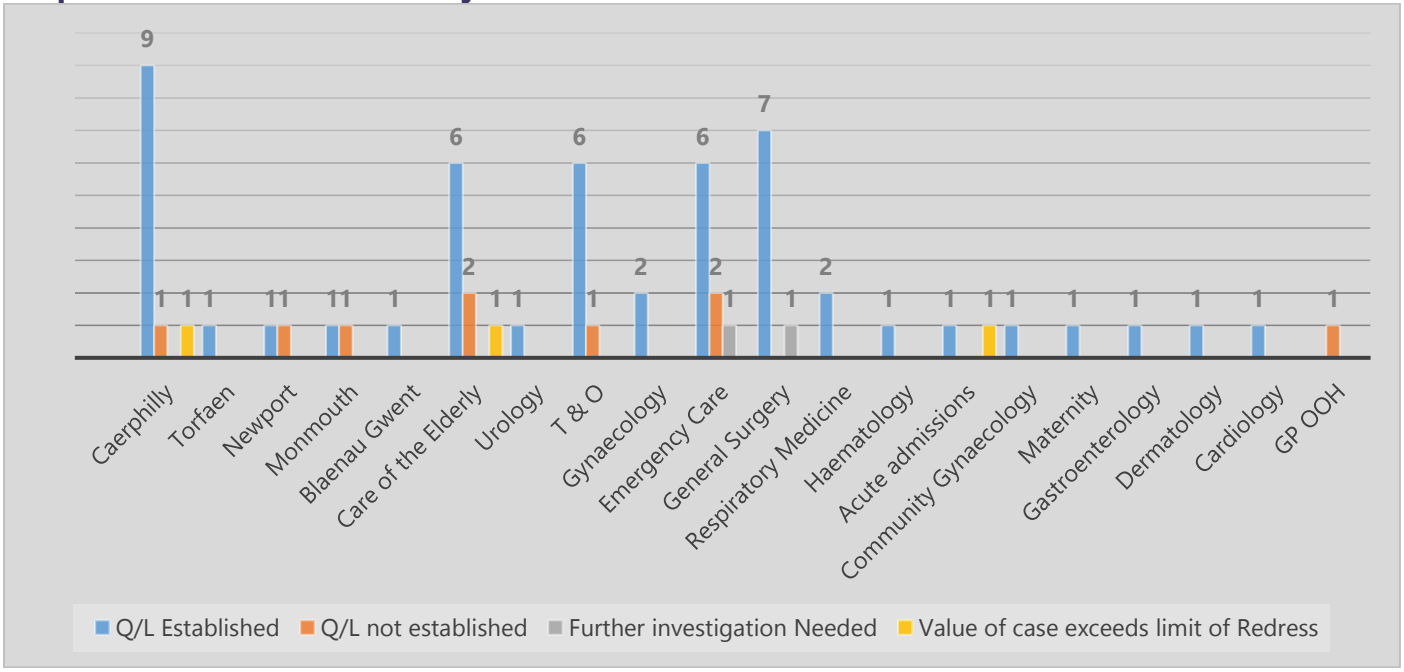
**Graph 13: Redress Cases 01/04/17 – 31/03/21**




**Graph 14: Decisions of Redress Panel**



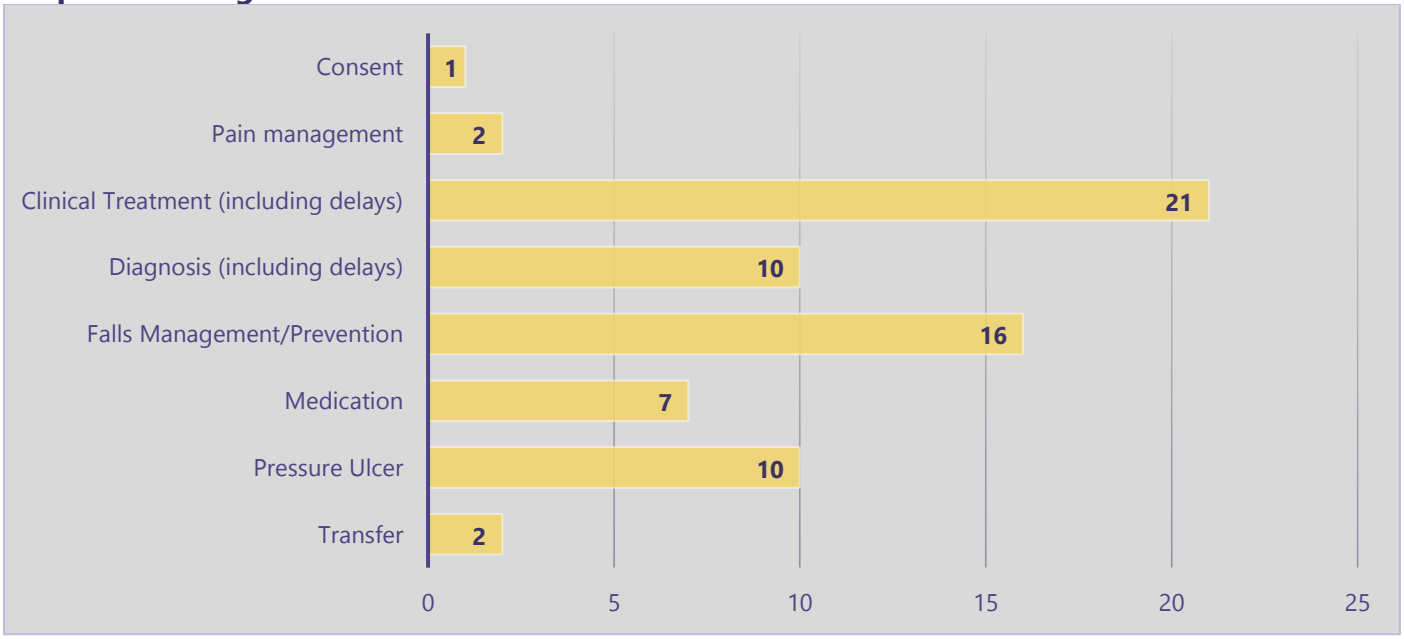
### Graph 15: Decisions of Panel by Directorate




## Themes of cases taken to Redress Panel

The majority of cases heard involved concerns regarding clinical treatment. Several cases in 2020/21 were linked to issues encountered with or during procedures undertaken; failures to undertake investigations, failures to escalate and a lack of senior review. However, of note is the sharp rise in the number of cases heard regarding falls prevention and management. Four cases were heard during 2019/20, whilst 16 cases were presented to the Panel in 2020/21. In the majority of cases there were failures to complete the multi-factorial risk assessment, failures to complete care plans but, in addition, half of the cases had concerns in relation to enhanced care (failures to implement, failure to identify this was needed). The number of cases heard involving pressure ulcers remained the same.

### Graph 16: Categories



## Lessons learned from Redress

In addition to making determinations of a qualifying liability, Redress Panel considers the learning from each and every case to ensure that learning is meaningful and adequate to help address the issues identified.
Learning routinely takes place on an individual and at directorate level (through reflection, discussions and education sessions). However, in a number of cases (particularly those involving falls) the learning has underpinned the work that is being undertaken at Health Board/corporate level.

Much of the work undertaken is subject to regular audit to ensure that the work undertaken is effective and efficacious.

There have also been the development of several pathways/operating procedures as a result of cases taken to Redress e.g. pathway for patients with Alzheimer's and Dementia for transfer to acute settings to ensure patients are transferred directly to appropriate settings that are able to meet their needs; there has been an amendment of pathway for chest injuries; standard operating procedure was developed at the Royal Gwent Hospital to ensure the movement of patients between wards and hospital was kept to a minimum to prevent disorientation.

Several cases were discussed/used as part of the thematic review of inpatient falls in single room environments. Similarly, other falls cases have also fed into the review of the Enhanced Care Policy and Guidance, which will include further education and awareness for staff on the use of the Enhanced Care Policy. An enhanced care record proforma has been developed and is in circulation to all areas. In addition, the Primary Care and Community Division are currently rolling out the use of the Enhanced Care Standard Operating Procedure across all wards and a pilot is currently being trialled for an individualised dynamic risk assessment approach to assessment of enhanced care requirements. Furthermore, a new initiative has been started to further enforce completion of lying and standing blood pressures. A proforma was developed which was put behind each patient bed with the dates the lying and standing blood pressure is to be completed.

# Serious Incidents (SI)

A Serious Incident is defined as;

*"An event which has involved either an act or an omission in relation to NHS funded care which has caused an adverse outcome, resulting in severe or permanent harm or death".*

All Serious Incidents are reported to Welsh Government's Delivery Unit (DU) and managed through the Serious Incident Process either as Red 1 (corporately-led) or Red 2 (divisionally-led) investigation.

The Health Board's requirement is to report, investigate and identify any learning within 60 working days of the incident notification.

Covid-19 has inevitably impacted upon formal reporting arrangements with a national steer provided in March 2020, advising adherence to the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 for the Putting Things Right process, wherever possible. However, it was recognised that due to the challenging times, it was necessary to undertake a proportionate investigation, but at the same time, still ensure candour with people raising concerns.

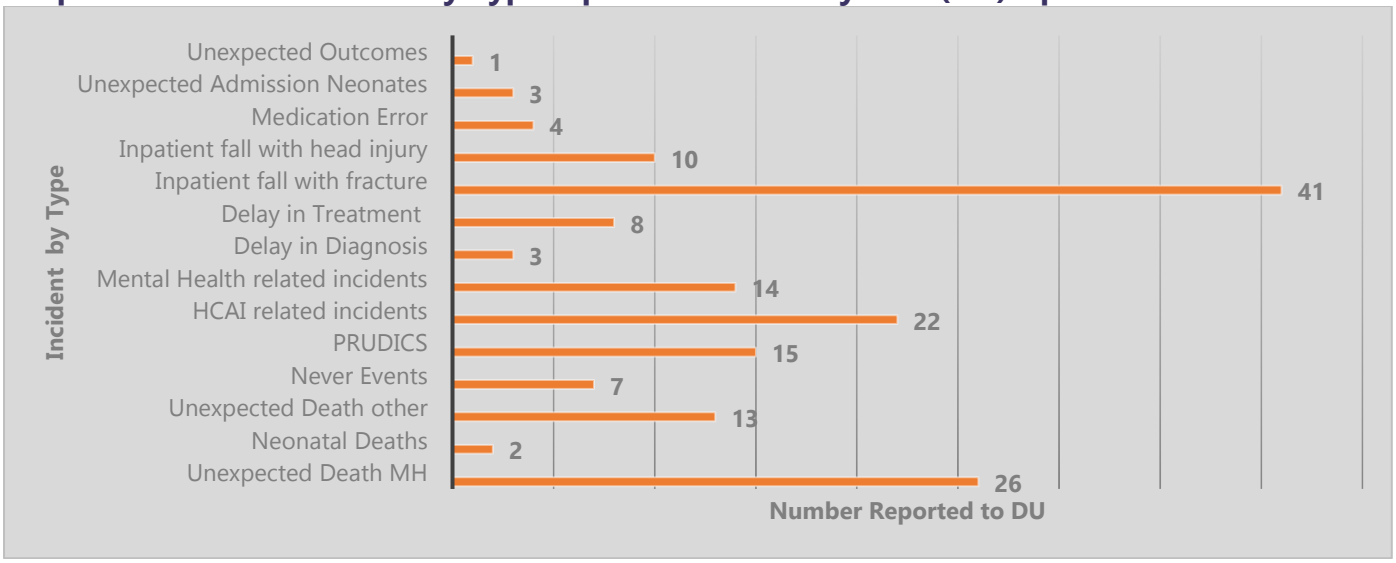
Therefore from 16 March 2020 to 16 August 2020, the Serious Incident reporting criteria was revised and reduced by Welsh Government. Even though this resulted in fewer serious incidents being formally reported, it did not prevent incidents being reviewed and investigated, where necessary.

Full reporting was reinstated from 16 August 2020. Following the second Covid-19 surge in late December 2020, Welsh Government reintroduced the reduced reporting criteria from 4 January 2021. Guidance was reissued which aligned to the steer provided in March 2020.

**23 of the reportable criteria were reduced to 6: -**

1) Never Events
2) Inpatient Suicide
3) Maternal Death
4) Neonatal Death
5) Homicide
6) Any other incident of high impact (for local decision)

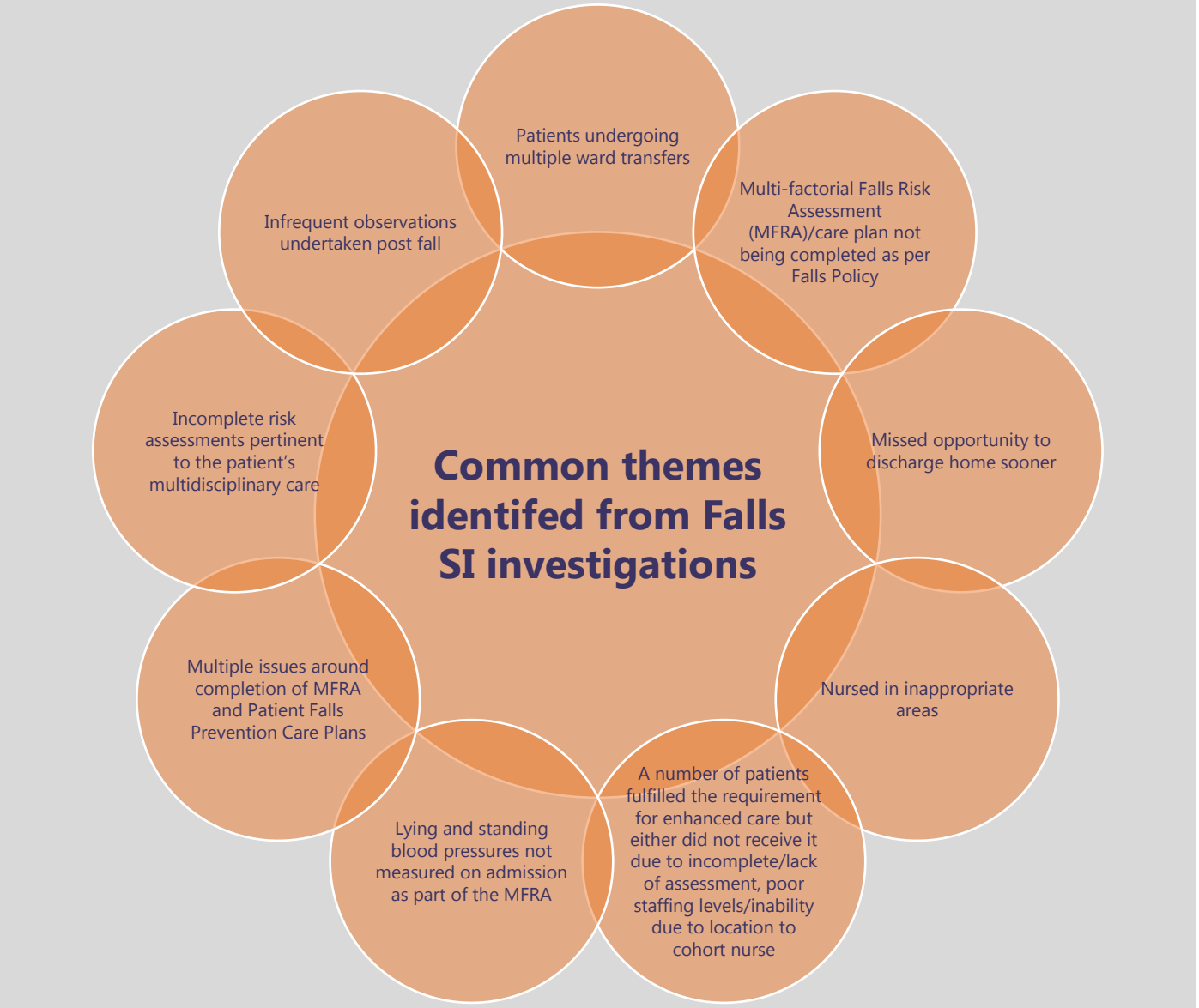
**Graph 17: Serious Incidents by Type reported to Delivery Unit (DU) April 2020–March 2021**




Of the 169 Serious Incidents reported to the DU in 2020/21, 36 were investigated via the Health Board's Red 1 Serious Incident investigation process (incidents which have resulted in severe harm or death).

The top three categories of reported incidents were: Falls, HCAI related incidents and Unexpected Death in Mental Health and learning identified from these are outline below: -

## Falls




The Falls Policy is being revised. There will be a campaign to raise the awareness of the policy and to provide support with its implementation.

## 1) Falls Thematic Review in Community Hospitals

An independent review around falls was commissioned by ABUHB Executive Team and commenced in March 2020. It was, however, subject to delay due to the pandemic and recommenced in July 2020. The review included key stakeholders interviews, along with observational and documentation reviews.

### Common Themes

- Timely and appropriate completion and update/review of the MFRA either following a fall, following a patient transfer or, as a minimum, on a weekly basis.
- Fulfilment of enhanced care requirements.
- Management of enhanced care in single room environments.

## Action Taken

A three tiered approach was used to obtain staff experiences for the provision of enhanced care in single room environments:

1) Ward manager experience of co-ordination, assessment and SBAR escalation for additional staffing requirement;
2) Registered nurse (RN) staff experience questionnaire conducted;
3) Health Care Support Worker (HSCW) focus groups held to gain an insight/understanding of the direct delivery of enhanced care.

## Outcomes of the review

- Continuous learning and improvement cycle for all wards supported by the Falls Review Panel action plan and Corporate QPS team.
- Continued support and steer for thematic falls review from the Falls and Bone Health Steering Group
- Fortnightly monitoring and reporting of unfilled shifts and triangulation and Datix reports for adverse outcomes.
- Sustained improvements noted at YYF and YAB and deep dives undertaken when a ward is noted for high incidence of falls.
- Initiatives and improvements led at ward level as a response serious incident reviews and coroner's inquests, such as introduction of the **Standard Operating Procedure** and patient folder for enhanced care provision.
- Further development with a pilot scheme on Oakdale Ward to test a risk assessment process to support dynamic and individualised decision-making to determine levels of enhanced care provision.
- Monitoring of Falls Review Panel action plan via Community Hospitals QPS meetings.
- MFRA and falls prevention training continues via a virtual model.

## 2) Healthcare Associated Infections (HCAI) related incidents

Healthcare associated infections are robustly monitored to rapidly recognise increase incidence (2 or more new cases in a 28 day period). In these circumstances, a Serious Incident (SI) meeting will be convened to explore a standard set of actions dependent on the organism. Of the 22 HCAI related incidents, Covid-19 and Clostridium Difficile incidents represented the majority (91%) of these.

## Learning from Clostridium Difficile Incidents

Six wards were affected by an increase incidence of C. difficile infection during 2020/21. Outbreak control meetings were convened, ward action plans were developed and monitored. Lessons and learning is discussed at Directorate/Divisional Governance and Patient Safety meetings.

Common actions include:

- Environmental decontamination using Hydrogen Peroxide Vapour (HPV)
- Audits of the environment and practices on the ward
- Hand hygiene assessments

Ribo-tying has indicated there were two instances where cases were linked and therefore cross infection had occurred.

Learning identified from C. difficile outbreak meetings include:

- Antimicrobial compliance
- The number of individual patient inter-hospital and ward transfers
- Compliance with hand hygiene audits (WHO 5 moments)
- Cleaning standards
- Prompt recognition and cubicalisation

## Learning from Covid-19 ward outbreaks

During the pandemic there were a number of delays in closing wards following a Covid-19 outbreak. As a result a number of actions were identified: -

- The Standard Operating Procedure (SOP) for results and the management of Covid-19 results were revisited. The case definition shared with the Infection Prevention Team.
- A dashboard for indeterminate, probable and HCAI Covid-19, together with an IPAC Triggers Dashboard was introduced.

## 3) Mental Health Unexpected Deaths

The most frequent category of serious incident within the MH & LD Division is unexpected death in community patients and of these, suspected suicide. There is ongoing work at a national (Wales) level to develop nationally agreed triggers and definitions for serious incidents in both mental health and learning disability. At the present time, the Division reports suspected suicide of patients who are currently known to primary and/or secondary mental health/learning disability services and those of people who have been known in the 12 months prior to their death.

The most recent report from National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) (2021) is inclusive of UK data between 2008 and 2018 with regard to deaths by suicide. The report notes that death by suicide is lowest in the ABUHB area at 9.4 per 100,000.

## 4) Mental Health Unexpected Deaths

Despite the methodology of the Division including more data than NCISH, the Division will continue to record this as this informs wider discussion in the Gwent Suicide and Self-harm Prevention Group – a partnership group with members from the Health Board, PHW, Police, Fire & Rescue and Third Sector organisations. As a result of this group, the Division is informed by Gwent Police 'in real time' of any suspected suicides of people known or previously known to MH or LD services thus enabling more timely communication with family members and a more timely review. The partnership commissioned a bereavement support service from '2 Wish Upon a Star' which the Division is able to link with in order to ensure support for family members of the patient.

The NCISH report was published in May 2021 and the Division is considering the findings and recommendations.

# Additional learning from Serious Incidents

## Learning in Acute Care

As part of a wider SI in which a patient experienced a delay in receiving medication, dedicated pharmacy support for the Emergency Department was secured. This provides a valuable resource in patient flow and access to timely treatment.

In response to a fatal incident at Nevill Hall Hospital in which a lack of enhanced care, reduced visiting and Covid-19 single room environment was a contributing factor, an enhanced care tracker was introduced as part of daily staffing plan, in order that available staff resources are appropriately distributed across the site to maximise patient safety.

Following a spate of knife crime in Newport, a review of security and safety arrangements for staff and patients in Royal Gwent Hospital's Minor Injury Unit was undertaken and an improvement plan developed in conjunction with Facilities.

As a result of an incident in which a patient was discharged home following a liver biopsy, without an appropriate anti-coagulation plan, a change in the management of patients in direct oral anti-coagulants (DPAC) undergoing liver biopsy occurred.

## Sodium Valproate prescribing for pregnant women under the care of Mental Health

There were two SIs in the Health Board where women became pregnant whilst taking sodium valproate which had been prescribed by their psychiatrists.

Work was undertaken by the Mental Health & Learning Disabilities Division, with support from the Primary Care and Community Division, Pharmacy and Neurology to list all females prescribed sodium valproate in order to identify who the specialist prescriber was, who should review, and thus ensure the completion of the Annual Risk Acknowledgement form.

Women are currently being invited to be reviewed and an annual audit will be established within the Division to ensure compliance with the standards.

## Coroner's Inquest – Regulation 28 response

Further to an SI that occurred within the Mental Health & Learning Disabilities Division in 2018, and the subsequent Coroner's Inquest in 2020, a Regulation 28 report was received in the Health Board. As a result, the PTR team reviewed the agenda to ensure that any independent contractors and external stakeholders are invited to SI meetings.

## Reduction in Absconsion from Acute Mental Health Wards

Ty Cyfannol Ward in Ysbyty Ystrad Fawr showed the highest incidence of absconding patients amongst wards in the Division. An extra set of doors has now been fitted to the ward which means staff have a greater ability to intervene and engage with the patient. The incidence of absconding from Ty Cyfannol has significantly improved.

## Healthcare Acquired Pressure Ulcers (HAPU)

Formal reporting of Pressure Damage to the DU was suspended in April 2020 due to the demands of the Covid-19 pandemic. From September 2020, notifications of significant pressure damage to Welsh Government resumed. These notifications are overseen by the PTR team for evidence of review and learning before executive sign-off. The Complex Care Team monitor and review all occurrences of pressure damage that occur within Care Homes to gain assurance around standards of care provision. All other Divisions monitor pressure ulcer prevalence and incidence through their respective quality and patient safety structures, closely monitoring Datix, conducting timely and thorough root cause analysis (RCA) and producing auditable action plans.

**DKA in Children**

In response to an incident concerning the identification and treatment of a child with newly diagnosed diabetes, covering both primary health and secondary health teams, it was ascertained that the history of children with co-existing nocturia and urinary tract infections indicating the possibility of emerging diabetes, can be misinterpreted. Therefore diagnosis may be delayed, leading to significant harm.

Actions identified following this were: -

- The importance for primary care clinicians to consider the new diagnosis of Diabetes in those presenting with non-specific chronic symptoms and more importantly the Toilet, Thirsty, Tired, Thinner (4T) symptoms.
- Face-to-face consultations for any child with any of the 4T symptoms in primary care, and same day referral to secondary care, as per newly diagnosed recommendations.
- Clinicians to have a low threshold to review a patient face-to-face in surgery when undertaking telephone or video consultations.

**Recognition of Ectopic Pregnancy**

A woman presented to the Emergency Department with generalised severe abdominal pain, 6 weeks pregnant, having collapsed at home.

The case was presented at the virtual monthly maternity and gynaecology clinical governance day, where learning points were identified and shared, in collaboration with ED:

- All women with suspected ectopic pregnancy need IV access, group and save.
- There needs to be effective multi-disciplinary communication and recognition of abnormal NEWs scores.
- The triage pathways between the Emergency Department and Gynaecology Services have been updated.
- There is a need for any women presenting with ectopic pregnancy who is a Jehovah Witness and declines blood products to be cared for by senior medical staff.

# Never Events

Never Events can be defined as:

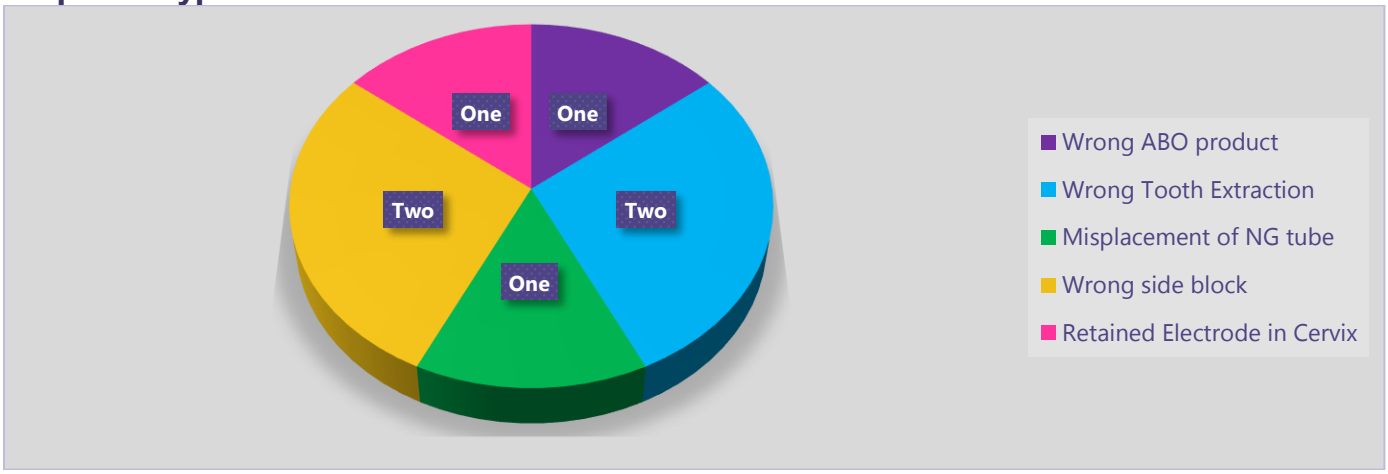
*"Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers".*

There were a total of **7** Never Events reported in 2020/21.

A number of theatre related safety initiatives have been implemented or are in progress to eliminate the incidence of Never Events, reduce patient safety incidents, encourage all disciplines to increase

reporting, and effectively communicate learning from events. The following describes practice improvements that have resulted as a consequence of the Never Event investigations.

**Graph 18: Type of Never Event**




## Learning from Never Events

### Wrong ABO Transfusion

- Activation of the alert system and prevention of manual override of Laboratory Information Management System (LIMS) will prevent incompatible plasma units issued in future. This alert function has been reviewed, tested and validated. This was implemented within 2 days of identification of the incident as an immediate action.
- Critical Care staff have received additional training with regards to the use of Covid-19 convalescent plasma.
- Plasma ABO compatibility charts have been added to the Transfusion Laboratory freezer and displayed in the clinical areas of Critical Care.
- There has been an update of the SOP in respect of convalescent plasma issue.
- Arrangements are in place to ensure that Welsh Blood Service can be contacted out-of-hours and at weekends in relation to Covid-19 convalescent plasma.
- Changes in the arrangements have been made with Welsh Blood Service who can be contacted out-of-hours and at weekends in relation to Covid-19 convalescent plasma.

### Wrong Tooth Extraction

- Work is underway to transfer the WHO checklist as an electronic document to be completed on ORMIS.
- Maxillofacial department staff training to improve oral communication during theatre procedures in line with Local Safety Standards for Invasive Procedures (LocSSIPS) and National Safety Standards for Invasive Procedures (NatSSIPS) to encourage staff to speak out if they have concerns during a procedure.
- All extractions under both GA and LA to include "Pause Before You Pull" when placing the forceps on the tooth just prior to removal. Changes to be reflected within WHO checklist.
- The NatSSIPS and LocSSIPS to be reviewed within a separate group to address standardisation, practices and processes.
- The Maxillofacial Team have joined the Theatre Safety Collaborative Group.

## Retained Electrode in Cervix

- Development of a SOP to standardise the actions taken by midwives and obstetricians when a Fetal Scalp Electrode (FSE) cannot easily be removed prior to emergency caesarean section.
- Inclusion of fetal scalp electrode status on the WHO post-operative checklist.

## Wrong Side Block

- Current discussions underway to standardise the prompt adopted within the Health Board such as 'STOP BEFORE YOU BLOCK' with updates to WHO checklists to reflect this.
- Clarity around use of 'Mark Before You Block' or 'Simulate Before You Block' – a neurocognitive approach incorporating a built-in action check. The clinician simulates a block by touching the skin with the separate empty syringe and confirms with the team whether this is on the correct side. There needs to be greater clarity for theatre teams on the processes for making sites for regional anaesthesia which differs if it is a stand-alone procedure compared to being part of a surgical procedure.
- Consideration to be given to dedicated block bays where the blocks can be safely performed with adequate resources and support.
- STOP BEFORE YOU BLOCK posters to be displayed in any environment where regional anaesthesia can be performed.

## Misplacement of Nasogastric Tube (NG)

- Improved concordance with documentation for NG Insertion and positional checks.
- Health Board wide alert disseminated to staff to advise of NG Tube Policy.
- Training for the multi-disciplinary team involved in the incident.

## Overarching Theatre Improvements

- An in-depth review of current safety checking processes and associated protocols prior to surgical procedures has been conducted throughout the organisation to identify risk and/or behaviours that may impact on patient safety and specifically where Never Events have occurred.
- The review encompassed ENT/Max Fax, Dermatology and all specialities where invasive outpatient procedures take place to prevent further wrong site incidents. Associated safety protocols and consent processes are currently being review and updated where necessary to reflect current best practice in Outpatient Departments.
- The Theatre programme is in early stages of development. It will focus on Theatre best practice standards and provide expertise to the Theatre teams in compliance with national guidance and NatSSIPS.
- Policy review is an integral part of the improvement programme using research-based references for development of local protocols.

# Learning Events

As a result of serious incidents, a number of learning events were run virtually, hosted by the PTR team, which facilitated colleagues to network from across the Health Board to share learning.

## 1) Falls Virtual Learning Event

During August 2020 a 'Falls' learning event was held. Unfortunately, due to the Covid-19 pandemic, it could not be facilitated face-to-face and was held virtually. It was chaired by the Executive Director of Therapies and Health Sciences, with 26 colleagues attending from a variety of disciplines.

Overall feedback was positive, with one Division clearly identifying with the themes raised, which encouraged shared learning. The benefits of sharing the pre-reading and PowerPoint presentation for further cascading in Divisions was noted as very helpful, along with positive discussion relating to falls work currently being undertaken.

Suggestions to further enhance future events were:

- To provide a summary of the story and focus more on the learning with clear recommendations to be shared across Divisions.
- To discuss a more recent case, if possible.

This was the first learning event held virtually and some helpful feedback in relation to IT included:

- Housekeeping before the meeting starts – all on mute, ask colleagues to be quiet if you are unmuted and talking, wear a headset if possible to help prevent interference.

An additional 'Diabetes Virtual Learning Event' was scheduled for December 2020 but sadly it was postponed, due to Covid-19 second surge. It has been rescheduled for May 2021 and will be held during Insulin Safety Week.

## 2) Gynaecology Simulation Learning Event

On 4 November 2020, a multi-disciplinary emergency gynaecology simulation training event was held at the Grange University Hospital. This cross-Divisional event was very well attended with doctors from both the Obstetrics and Gynaecology and Emergency Departments, as well as nurses and health care assistants from both specialities.

The first part of the event involved two simulation-based scenarios covering gynaecological emergencies, including ectopic pregnancy and heavy vaginal bleeding. This session allowed 'hands on' practice in managing emergencies and effective communication in a safe environment. It was a great opportunity to break hierarchical barriers and develop multi-disciplinary teamwork.

The practical simulation was followed by a lecture from one of the gynaecology consultants highlighting learning points from two Serious Incident cases relating to 'managing ectopic pregnancies'.

The idea for developing emergency gynaecology simulation training has been around for a couple of years in Newport. It has been motivated by the successful and nationally recognised evidence-based multi-disciplinary training in obstetrics called PROMPT (Practical Obstetric Multi-Professional Training) which was found to be associated with improved clinical outcomes. Recently a faculty team has come together for the first time to discuss the future of the project. The vision is to make this a regular training opportunity that can expand to other Welsh hospitals and beyond.

## 3) Mental Health & Learning Disabilities Virtual Learning Event

A learning event was held virtually on 21 December 2020, to share some of the themes of the Serious Incident report and the recommendations made with the staff who were involved in the incident. Initially, the plan was that this event should be held face-to-face and with representation from the supporter of the patient's next of kin. Unfortunately, the pandemic meant that the session was held virtually and due to a bereavement, representatives of the patient's family were not able to attend but gave permission for the event to go ahead.

The event was supported by the Executive Director of Nursing and Vice Chair of the Board. This was well-received and reinforced to participants that the purpose of the day was to share learning from the incident. Two sessions were held virtually in the same day - this allowed for all involved staff to attend should they wish. Attendance was very good and included representation from all professional groups; Psychiatry, Nursing, Psychology and Occupational Therapy.

The first part of the session focussed on feedback and recommendations from the report, with an update on the progress of the action plan generated in response to the recommendations. The second part of the session split participants into focus groups. The groups invited people to reflect on the findings shared and to think about the following:

What is our learning – what can we do differently? Reflect and discuss from the following perspectives:

- Individual
- Team
- Organisational
- Wider Wales

Groups then fedback to the wider session and these reflections were collated. These have been published into a booklet for participants as a personal record, also to inform service development at the above levels within the wider system.

Feedback from participants was good, with helpful, honest and constructive thoughts and suggestions shared.

# Partnership Working

## 1) Community Health Council (CHC)

The Community Health Council (CHC) has continued to support people in raising their concerns with the NHS in a meaningful and purposeful way throughout the past year. Whilst NHS staff were deployed to help in areas of pressure, the CHC and the Health Board's PTR team maintained contact in order to ensure communication and early resolution of concerns.

The CHC advised that having dedicated points of contact within the Corporate PTR Team, along with quarterly catch up meetings ensured a collaborative approach and robust communication. This ultimately benefited CHC 'clients', with responses that were timely, qualitative and meaningful.

## 2) Ethnic Youth Support Team (EYST) / Black, Asian and Minority Ethnic (BAME) Forum Presentation

In October 2020, PTR Senior Managers were keynote speakers on a virtual forum following a request by the Gwent Regional Co-ordinator for EYST All Wales BAME Engagement Programme. The aim was to talk about the PTR process in order to appropriately inform people as to how they can access the service, offering reassurance of confidentiality.

It is well recognised that people say that they don't like to make a complaint about their experience as an inpatient or outpatient as they feel that their care could be compromised. The presentation was well received. It also provided an opportunity to advise the BAME community that PTR are available to support if they decide to raise a concern. Reinforcing that if they do raise a concern care will not be compromised and that it is seen as a positive to assist with learning.

## 3) Welsh Ambulance Services NHS Trust (WAST)

Monthly meetings have been convened with the PTR team, Associate Director of Operations and Patient Safety leads within WAST. The regular meetings enable opportunity for discussion of incidents raised, ensuring a collaborative approach is adopted and learning shared.

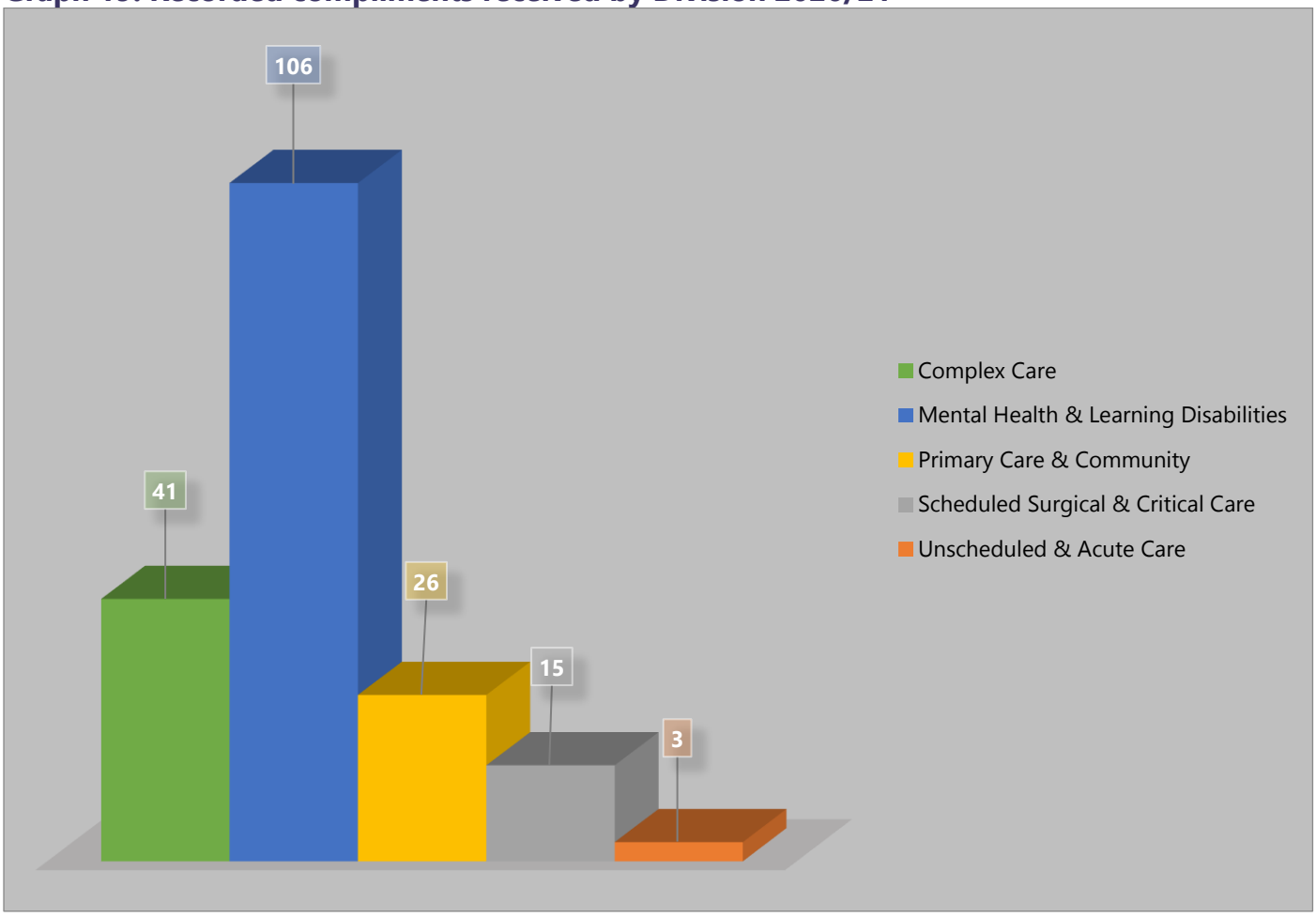
It has strengthened relationships and communication and ensured timely discussions are undertaken regarding specific cases.

# Compliments

Compliments are received within a variety of formats, including letters, emails, telephone calls, thank you cards and conversations. Compliments are useful for measuring and tracking feedback. They can demonstrate improvements in performance and provide a baseline for measuring patient satisfaction, generating meaningful data can help drive continuous improvement. Compliments acknowledge, reward and promote desirable behaviours and practices, also providing staff with social recognition. Positive feedback is pivotal for morale and wellbeing, and reinforces what the Health Board is striving to provide.

The capturing of compliments data remains challenging.

**Graph 19: Recorded compliments received by Division 2020/21**



**C7 East, Royal Gwent Hospital**
**22/06/2020**

Gratitude and heartfelt thanks to every member of staff that dealt with my mother, from the young man on security at the carpark entrance, catering staff and all the nursing staff. She was treated with respect, compassion, professionalism, care and understanding and that nothing was too much trouble.

**C6 East, Royal Gwent Hospital**
**06/10/2020**

We couldn't have got through without the amazing team on C6 East. My father felt safe during his final stages of life. Thank you.

**Vascular Department, Royal Gwent Hospital**
**04/08/2020**

Thank you for the outstanding care and support they have provided my father. It has been very difficult for the family not being able to visit the hospital and small gestures such as encouraging Facetime with the family and setting up the iPad so he can watch TV, as well as providing regular updates have been a real help.

**Day Surgery, Nevill Hall Hospital**
**01/02/2021**

Staff were respectful, kind and caring during my gynaecology operation.

**Torfaen Memory Clinic**
**30/07/2020**

G with her dedication, kindness, care and always going the extra mile to help my wife and I.

**AO, Grange University Hospital**
**19/01/2021**

Thanks for the care my mother received not only just medically and physically but emotionally from all the hospital staff, ranging from the domestic staff, nursing staff and to consultant level was outstanding.

**Mental Health**
**19/01/2021**

This lady is really happy with the care and support she received when going through her pregnancy. The perinatal mental health team who helped her during such a difficult time. She shared that from the very start her mental health had been considered and with her anxiety being through the roof during her pregnancy she was never made to feel like she was exaggerating or making a fuss and was always listened to 100%. So much so that she wishes to nominate Dr J and the Perinatal Mental Health Team to the ABUHB's staff awards for their outstanding contribution.

**GP Out-of-Hours**
**25/08/2020**

The member of staff wishes to share how proud she is of the Out-of-Hours Team during such challenging times. She highlighted a case where the GP was called out to the family of a palliative care patient who was getting married. On the way to the patient's home, the mobile team stopped and bought several bunches of flowers as a nice gesture as the wedding ceremony was that day. The patient sadly passed away at 3am the following morning.

**Cedar Unit, County Hospital**
**05/11/2020**

Very happy with the friendly and helpful staff, the nurses explained the reason for treatment and the possible side effects.

**Ward 3/4, Nevill Hall Hospital**
**06/07/2020**

A very big thank you to all the staff on Ward 3/4 at Nevill Hall for the care they provided, how kind and considerate the staff were making the experience positive.

**Endoscopy, Ysbyty Ystrad Fawr**
**13/12/2020**

Share my thanks for the care received whilst at the Endoscopy Department. The staff, in particular Nurse L who looked after me post-procedure, showed such kindness and respect, which was highly appreciated.

**Women and Children**

The Aneurin Bevan University Health Board Maternity Services Facebook page now has over 8,103 followers, with a reach of 82,000 people, sharing information about maternity services for women and their families, and to promote choice and confidence through interaction and key messages.

The feedback from women repeatedly talks about kindness, compassion, feeling safe, being listened to and feeling cared for. Average of 15-20 positive feedback/positive birth story posts a week with photos, tips and reassurance for other women. This is over 21% of all women birthing at ABUHB.

**Compliments received via Social Media**

"Hi Judith, just a quick message to say how grateful we all are as a family for the measures that have been put in place regarding my father's stay at the Grange. The staff could not be any more accommodating and helpful".

**Compliments sent directly to the Chief Executive**

**A thank you to staff at Outpatients, YYF**
*"We have been most impressed by the friendly, courteous and helpful attitudes displayed by staff, regardless of grade or role".*

**A compliment to A&E, RGH**
*From the moment I arrived at A&E till the moment I left... I could not have been treated better in the best private hospital! I was made to feel like my case was important and at all times treated with great respect and kindness".*

**A compliment to Endoscopy Department, YYF**
*"Today I felt respected and further, I felt, within the constraints of the decisions I indicated on the special consent form, I would be fully and safely cared for. I was shown nothing but kindness and respect. I appreciate this very much. I do hope you will take the trouble to pass on my deep appreciation to this wonderful team".*

**A compliment for X-Ray and the Breast Care Specialists**
*"I am writing a letter of thanks and gratitude for the wonderful care I received as both an inpatient and outpatients within ABUHB... I will be eternally grateful for the exceptional and superior care I have received thus far".*

**A compliment regarding Lymphoedema OPD, St Woolos and Cedar Unit, County Hospital**
*"Both visits showed that you have extremely capable, well-trained staff, due in no small measure to you as CEO and your Management Team".*

# Conclusion

During the pandemic the Health Board used a "proportionate approach" to ensure rapid handling of concerns/complaints/serious incidents and de-escalation where possible. The PTR team worked closely with Divisions and Legal Services to support this approach, to ensure organisational responsiveness in line with PTR Regulations. The changes primarily focussed on any investigations being proportionate, reinforcing the importance of honest communication with people raising concerns, but critically not raising expectations.

As the organisation stabilises from Covid-19, it is important to refocus on the fundamental principles of Putting Things Right and re-embedding the agenda as being owned by everyone.

There has been a year on year improvement in organisational performance for the timely management of complaints and the quality of responses is improving.

Despite the pandemic, learning events have been held and thematic analysis of concerns has strengthened.

Based on the 2020/'21 issues, a work programme has been development for focus during 2021/'22, as outlined in the following table.

# PTR Annual Programme
# 2021 - 2022

| | | |
|---|---|---|
| **Priority 1** | Implementation of Patient Safety Incidents Policy *(due for launch on 14 June 2021)* | This policy represents a new SI reporting framework focussing upon shared learning and quality assurance. The Corporate PTR team will lead this through a series of 7 minute briefing releases through Comms, Q&A open sessions and liaison with the Divisional QPS leads aligned to the SI process. |
| **Priority 2** | Implementation of RLDatix *(due for launch in May 2021)* | In collaboration with the Health Safety Team, roll-out through divisional concerns hubs and co-ordinators. The Once for Wales Concerns Management System Programme is aimed at bringing consistency to the use of the electronic tools used by all NHS health bodies. It will provide integrated functionality to support a range of essential patient safety and experience functions; Incidents Reporting & Investigation, Complaints Management & Investigation. |
| **Priority 3** | Preparedness for the Health and Social Care (Quality and Engagement) (Wales) Act | Further embedding the Duty of Candour, the cornerstone of the Putting Things Right Regulations (2011). |
| **Priority 4** | Covid Claims agenda | PTR to engage with Legal Services and Executive Team in liaison with Welsh Risk Pool to address health care acquired Covid-19 related infection concerns raised. |
| **Priority 5** | Care Aims and progression of Organisational Learning | Continue to develop a person-centred, rather than a problem-centred, approach to complaint responses. Encompassing a core set of principles, of justice / fairness, transparency, empowerment of service users, promotion of self-help and personal responsibility. Plans are in place to develop care aims further. The inaugural scoping meeting is scheduled for June 2021. |

| | | |
|---|---|---|
| **Priority 6** | Learning Framework | Develop a Learning Framework to strengthen organisational learning. |
| **Priority 7** | Improvement in SI Reporting and Performance | Further improve compliance to targets. |
| **Priority 8** | Mortality Reviews | Engage with Medical Examiner focussing upon concerns generated following mortality reviews. PTR to sit on proposed scrutiny panel for such cases. |
| **Priority 9** | Newsletter | Introduce a quarterly Newsletter. |