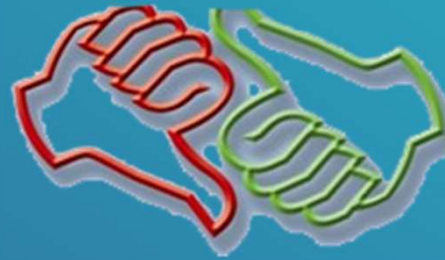


Putting Things Right Annual Report 2020-2021

**Concerns (Complaints,
Claims and Adverse
Incidents)
and Compliments**



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Introduction

Public Health Wales is an organisation which welcomes concerns (incidents, complaints and claims) as a way of improving the services and programmes we provide. The organisation accepts that it does not always get things right and sometimes fails to meet service users expectations. When this happens Public Health Wales is committed to doing what it can to put things right and learn, thereby reducing the risk of repeat occurrences.

Feedback is therefore important as it provides the chance to change and enhance the quality of the services and programmes provided as appropriate. It also provides an opportunity to learn from concerns to improve our services, programmes and the experience of service users and stakeholders. This year we have had to learn and adapt our response to the pandemic, by listening to the people who have contacted us and applying the principles of PTR to unique and extraordinary circumstances.

In support of the policy direction set by the First Minister of Wales in Leading Wales out of the Coronavirus Pandemic and delivery of the Welsh Government's Test Trace Protect Strategy, Public Health Wales has mounted an unprecedented health protection response to the coronavirus pandemic since early 2020. This has impacted on all areas of our normal activity and the management of concerns was no exception.

Public Health Wales continues to be proactive in its management of concerns. The report provides an over view on the reporting period April 1st 2020 to the 31st of March 2021 and builds on the strategic arrangements required to oversee the implementation of the NHS to follow the Welsh Government Guidance on *Putting Things Right* (PTR) (Concerns, Complaints and Redress Arrangements) (Wales) Regulation 2011.



Putting Things Right: An Overview of 2020/2021

Formal complaints: 71

Response times

Acknowledged in 2 working days: 66%

Final response within 30 working days: 49%

Informal complaints: 72

Compliments: 1178



Potential Redress: 5

New Claims:
Confirmed 6
Potential 7

Serious Incidents 6

Never events: 0

Complaints Process, Governance and Reporting Arrangements

- ❖ All concerns received by Public Health Wales are handled in accordance with the regulation for concerns and redress arrangements. A single point of contact has been established which details the Responsible Officer's contact information.
- ❖ Divisional Directors are responsible for appointing a lead investigator and for ensuring that investigations are carried out in accordance with the Putting Things Right Regulation, Guidance and Public Health Wales Policy.
- ❖ All final responses are reviewed by the Chief Executive prior to them being sent to the individual concerned. The aim is to provide a full response within 30 working days of receipt of the concern. However, in exceptional circumstances, where further investigation is required or there is involvement with other Health Boards or external organisations, this may not be possible.
- ❖ The individual raising the concern is always invited to discuss their concern with an appropriate member of staff and / or the Responsible Officer.
- ❖ In order to ensure scrutiny of the management of concerns and where a potential for redress is identified, the Executive Team acts as the Redress Panel for determining qualifying liability and level of compensation to be awarded. The panel is chaired by the Executive Director for Quality, Nursing and Allied Health Professionals (Responsible Officer).
- ❖ The Putting Things Right (PTR) quarterly report is presented to the Business Executive Team and Quality, Safety and Improvement Committee. The reports detail the complaints, incidents and claims received and enables patterns and possible 'hot spots' to be identified via the triangulation and analysis of this data. This assists with providing assurance to the Board, Executive Team, Quality, Safety and Improvement Committee and the public on the organisations commitment to continually improve services

Complaints Activity

- ❖ In 2020-2021, 71 formal complaints were received and investigated under the Putting Things Right – Handling Concerns regulations which is an increase on the previous year and in the main relate to COVID 19. Health Protection has had the highest number of complaints, is due to the increased public contact by the division during the pandemic.
- ❖ During 2020-2021 the national population based screening programmes screened a total of 357,000 participants the ratio of complaints to persons screened equates to 1:13731 (0.007%)
- ❖ In addition a total of 73 'on the spot' complaints were received for the period.

Table 1 depicts the number of formal complaints received from 01 April 2011 to 31 March 2021 and shows that over this period the number of complaints received has remained relatively low and stable.

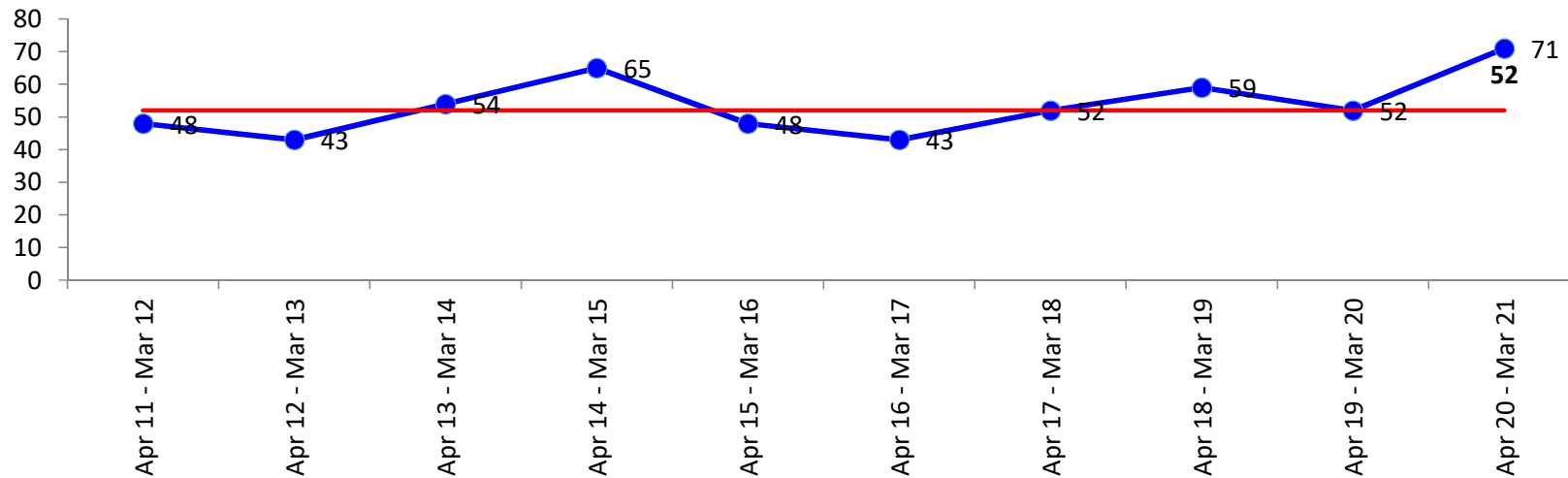


Table 1 – Formal Complaints received Apr 2011 – March 2021

Complaints Categories

The categories for both the formal and 'on the spot' complaints received are as follows :

Complaints received by category



Table 6 Complaints received by category year ending March 2021

The table indicates complaints received for the period 1 April 2020 – 31st March 2021 by reported category. The main category reported was treatment / procedure which includes themes such as appointments, attitude / behaviour of staff and communication issues. This information enables the organisation to analyse the causes, trends and themes of complaints for our service users. The analysis is also used to learn from complaints and inform improvements in our services. In response to the main reasons for complaints i.e. appointments, attitude and behaviour and communication issues the learning that has resulted includes:

- ❖ The importance of clear communication with users of our services
- ❖ Staff reflections about perceived attitude and behaviour
- ❖ Update to 'Cancelling Clinics' SOP to ensure that the cancellation of clinics within five working days is undertaken via phone contact.

Claims

Public Health Wales has a relatively small claims profile. Claims are reported via Datix and managed with advice and support from Legal and Risk Services. All claims are managed and analysed to ensure that lessons are learnt in order to reduce risks of reoccurrence and improve services.

At the end of March 2021, there were 25 open confirmed and potential claims, of which all relate to clinical negligence. During the reporting year 6 new confirmed claims and 7 potential claims were received. Public Health Wales also closed 5 claims and 2 claims were settled. In addition Public Health Wales conducted further investigations into 4 concerns to establish whether there was a qualifying liability in tort and Regulation 24 responses were provided.

An internal audit of the claims reimbursement process was undertaken by the NHS Wales Shared Services Partnership Audit and Assurance Service in the form of the Welsh Risk Pool Claims Audit in March 2021 to determine the adequacy of the systems and controls in place. Public Health Wales achieved **substantial assurance** and there were no recommendations as a result of the audit for Public Health Wales to action.

The table below shows a comparison of new claims received during each financial year up to the end of March 2021.

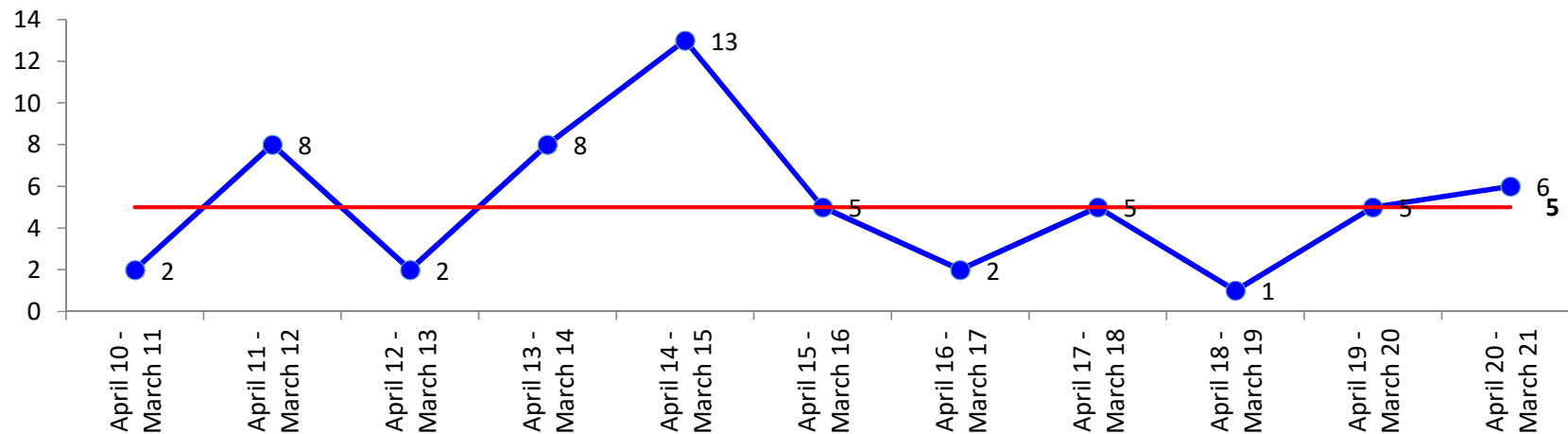


Table 7 – New confirmed claims by year April 11 – March 21

Patient and Client Incidents

Patient and client incidents are reported via Datix and an analysis of these incidents are reported to both the Business Executive Team and the Quality, Safety and Improvement Committee via the quarterly Putting Things Right Report.

Public Health Wales Health Board actively encourages all staff to report all incidents including those categorised as near misses. Incident reporting is one of the mechanisms that the organisation utilises to gain learning and drive improvements.

Any incidents that have caused significant harm are reported to the Welsh Government and managed via the Serious Incident process. Six serious incidents were reported to Welsh Government in 2020/21 and none of the investigations were completed within target timescales. This was caused by resources being diverted into the Covid19 response.

The below chart suggests that there has been little variation in the number of patient and client incidents reported from April 2014 – 31 March 2021 which indicates that the number of incidents remains relatively stable.

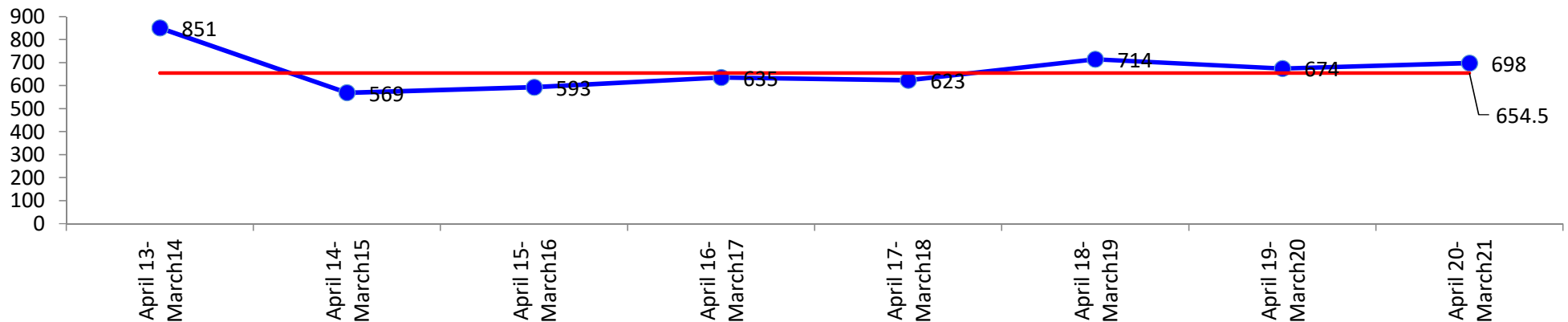


Table 8 Patient & Client Incidents reported year ending March 2021

Compliments

We value feedback and actively encourage people to contact us to share their experience. During 2020-2021 we received a total of 1178 compliments

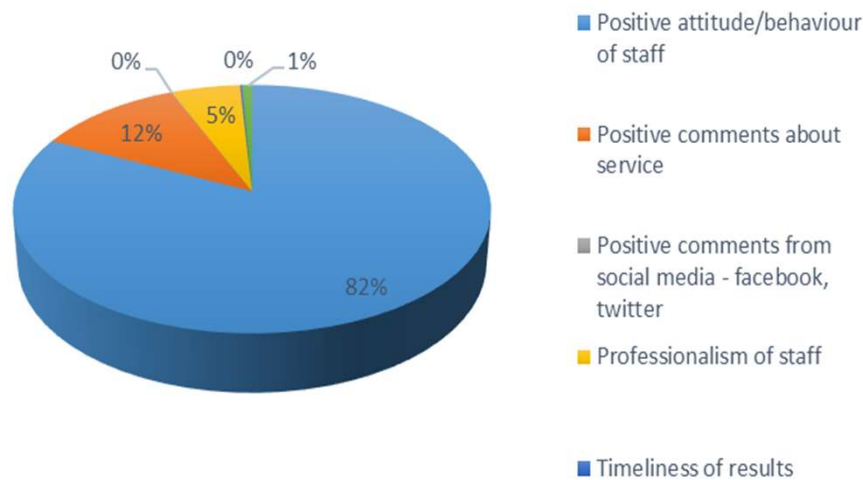
AAA

She put me at ease, was very friendly, informative and professional. Simple procedure and reassuring result.

Microbiology

I just wanted to highlight the amazing help that I received from a support worker during my night shift.

Compliments received Apr 20 - Mar 21



Bowel Screening Wales

A good process, well delivered and a good experience on the actual day of screening.

Ratio of Compliments to formal complaints: 17:1

Our Learning

You Said

We received a complaint from someone we had contacted to take part in a public engagement survey on the effects that the COVID-19 measures in Wales had on health and well-being. They were concerned about the number of calls they received and whether we had accessed medical records when choosing people for the survey.



We Did

To improve the service, we now provide clearer information on our website about the survey and how we choose people to take part. We agreed to continue to provide this information for future surveys for those people who want to check out surveys and be reassured that their information will stay anonymous and confidential.

Concerns raised in relation to the Antenatal Screening Wales health professional website and the difficulties encountered in locating documents



Relevant individuals will be will be advised of and trained when a significant change to the web sites are undertaken

Participant received an open invite letter and declined the offer and was placed on 'Appointment Offer Declined' and DNA letters were sent to the participants GP and Diabetologist. The participant was concerned that the letters to healthcare professionals did not accurately reflect his informed decision to decline



Current letter wording to be amendment when IT system is upgraded.

Summary of priorities for 2021-22

- ❖ Ensure a more systematic and integrated approach to learning lessons from incidents and complaints via the triangulation of data, identifying any themes and trends
- ❖ To bring performance standards back to those enjoyed pre-Covid19 and to improve upon them
- ❖ To work across the organisation to drive up the quality of data in Datix (and the forthcoming Once for Wales Concerns Management System), to enable a more data driven approach to quality improvement
- ❖ Duty of Candour and a new national Serious Incident Framework, which is currently under review. Implementation of the requirements of the Quality Act 2020, including the Duty of Candour and the Duty of Quality, supporting Directorates to better respond and improve on issues arising from Concerns
- ❖ Continue to work with Divisions to manage complaints and improving the number of responses sent within the 30 working day timescale to the ensure compliance with 75% response target set by the Welsh Government and the 95% organisational response target is achieved
- ❖ To build on the work that has been done in previous years a review of all Policies and Procedures connected with PTR is to be undertaken to capitalise on the opportunities presented to by the Once for Wales Concerns Management System and the Health and Social Care (Quality and Engagement) (Wales) Act 2020.
- ❖ To take a more integrated approach to improvement through the implementation of the Quality and Improvement Strategy and Integrated Governance module take a matrix approach.
- ❖ Ensure the annual programme for the organisational Quality and Clinical audit plan is informed by themes, trends and learning opportunities provided through the data captured from Datix and analysed by the Quality Nursing and Allied Health Professionals Directorate in collaboration with the wider Directorates.