GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 16 May 2023 **Agenda item:** 4.3b

Putting Things Right Annual Report 2022/2023

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Approval/Scrutiny route:	Business Executive Team/ Quality, Safety and Improvement Committee

Purpose

This paper introduces the Putting Things Right Annual Report for 2022-2023.

Recommendation:

APPROVE	CONSIDER	RECOMMEND	ADOPT	Assurance
☐	☒	☐	☐	☒

The Quality, Safety and Improvement Committee is asked to:

- Note and take **assurance** on the Putting Things Right Annual Report for 2022/23

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities. **This report contributes to all strategic priorities**.

Summary impact analysis	
Equality and Health Impact Assessment	An Equality and Health Impact Assessment is not necessary as no decision is required.
Risk and Assurance	N/A
Health and Care Standards	This report supports and/or takes into account the Health and Care Standards for NHS Wales Quality Themes Governance, Leadership and Accountability Person Centred Care Theme 1 - Staying Healthy
Financial implications	There are significant risks in failing to manage the 'Putting Things Right' process effectively, including the risk to service users and staff because of failing to learn lessons from events, and the financial and legal sanctions possible from causing avoidable harm.
People implications	N/A

Contents

1. Introduction

This report summarises the feedback received from service users and their representatives during the period 1st April 2022 to 31st March 2023. This report covers in detail complaints, incidents, claims, Redress, and compliments as set out in the "Putting Things Right" (PTR) arrangements. The term '*Concern/s'* will collectively refer to incidents, claims, Redress, complaints, and compliments for the purpose of this paper.

Public Health Wales recognises that effective, service user and public involvement/engagement is an important aspect of our governance arrangements and the importance of learning from events to support the development and improvement of services. Public Health Wales is therefore committed to the provision of effective services, functions and programmes and timely processes for responding to concerns, which enables the Trust to improve services based on lessons learnt.

This annual report also details compliance with the response rates set out in the Putting Things Right Regulations, together with an overview of the concerns reported through the process for the period 1 April 2022 to 31 March 2023.

2. Aim

This annual report is prepared in accordance with:

Regulation 51 of the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations of which Regulation 51 provides that a responsible body must prepare an annual report.

3. Summary

Table 1 shows the activity level for each type of feedback received in 2022-23.

Table 1: Breakdown of feedback received

	2021/22	2022/23
Incidents Total	2,732	2,013
Formal Complaints	84	30
Early Resolution Complaints	115	73
Redress Cases	5	4
Clinical Negligence Claims	2	3
Personal Injury Claims	0	2
Compliments	1,985	1,589

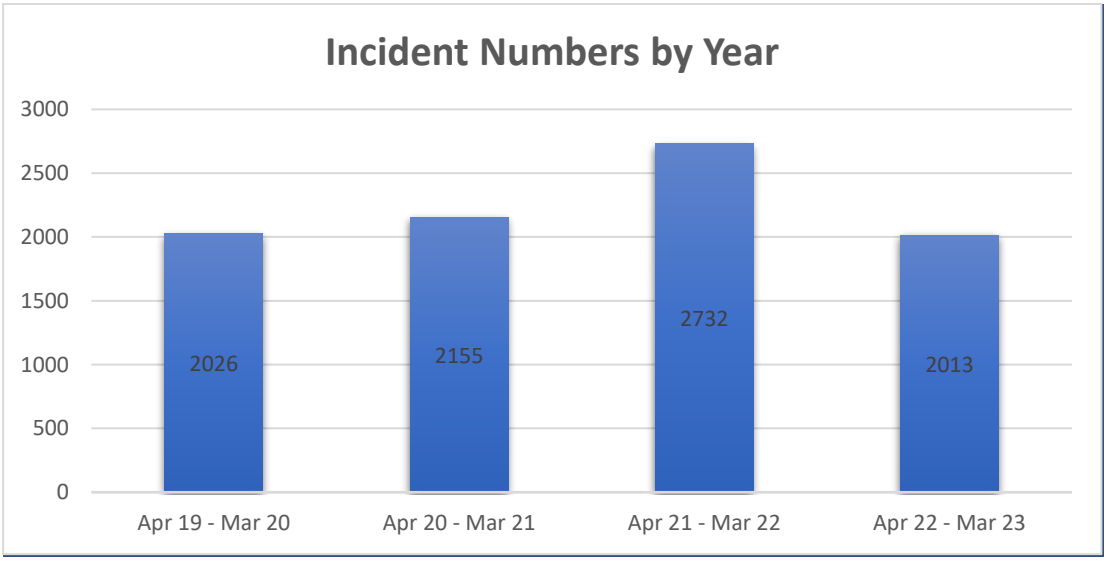
4. Incidents Overview

Incidents are reported via the Datix Cloud Concerns Management System and reported to both the Business Executive Team and for assurance to the Quality, Safety and Improvement Committee via the quarterly Putting Things Right Report.

In 2022/23, 2,013 incidents were reported, a reduction of 719 compared to 2,732 reported in 2021-22. Whilst this seems to be a significant decrease it is important to note that from August 2022, Microbiology began using the

ipassport system, as a platform for recording their error-non incidents which supports with the requirements to record these to support with their UKAS accreditation.

Graph 1: Number of incidents received by year

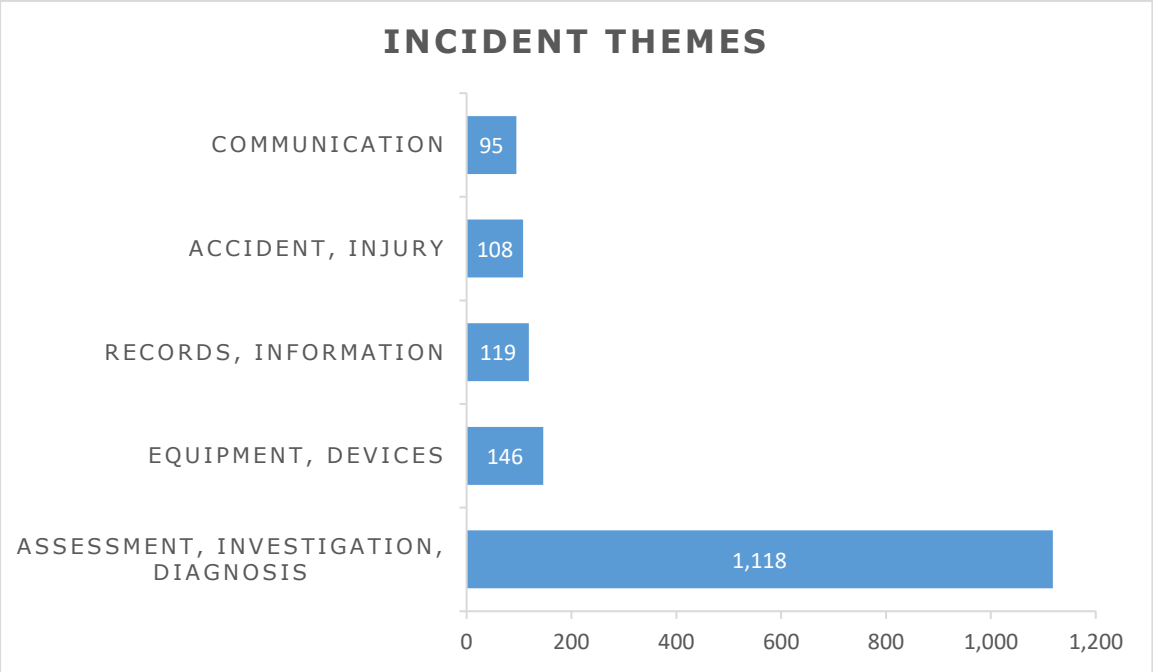


Graph 2 below demonstrates the most common reported incident's themes.

62% (697) of incidents reported under the category of 'Assessment, Investigation, Diagnosis' relate to Cervical Screening Wales, and mainly include cervical smear taker errors which are not directly attributable to Public Health Wales direct services but those that are commissioned by us. These incidents are reported by CSW staff and coded as error non incidents.

Of the remaining incidents in this category 31% (344) of these incidents reported relate to Microbiology. Some of examples in this category include laboratory technical errors, delay in testing or processing samples and failure to follow Standard Operating Procedures.

Graph 2: Top 5 Incident themes reported in 2022-23



4.1 Levels of Harm

When reporting an incident on Datix, the reporter will be asked to provide their assessment of the level of harm that has occurred as a result of the incident. The Harm Levels reported by initial reporters are shown in Table 2.

Table 2: Reported incidents categorised against level of harm

Level of Harm	Number of Incidents
None	1,294
Low	534
Moderate	47
Severe	6
Catastrophic / Death	2

It is important to note that the initial level of harm assessment is made by the reporter's best judgement often with limited information available at the time of reporting. As further information becomes available during the investigation process, the investigator will amend the level of harm if appropriate to do so.

All incidents, including nationally reportable incidents (NRI's) are reported as soon as possible and at this point the reporting member of staff should

assesses whether an action or inaction in the course of a service users care or treatment in a health care setting has or is likely to have caused or contributed to an unexpected death or severe harm. NHS Wales provides a clear set of definitions describing the levels of harm for all NHS staff to use. At the point of reporting, it is not always possible to determine the extent to which an incident has caused or contributed to harm and a subsequent investigation determines this. An incident can be downgraded if the initial assessment is incorrect against these NHS definitions after an investigation has established all the facts.

This year a total of 2 incidents initially recorded as 'catastrophic /death were subsequently regraded following this investigation process. The incident severity in both cases were initially coded by the reporter against the outcome for the individual person affected but should have been coded against the 'type' of incident and the level of harm caused as a result of NHS funded healthcare. One case related to a member of the public collapsing in a car park from a cardiac arrest and sadly dying despite the efforts of PHW staff and the emergency services the other as a result of a delay in reporting a microbiology sample result . Their deaths however were not caused by any PHW healthcare interventions or lack of interventions and so the incident grading was amended to correctly reflect this in line with NHS Wales guidance.

4.2 Nationally Reportable Incident / No Surprises / Never Events

Table 3: Nationally Reportable Incident / No Surprises / Never Events

Number Reported	2021-22	2022-23
Nationally Reportable Incidents reported to Delivery Unit	4	5
No Surprises reports submitted to Welsh Government	5	9
No Surprises reports submitted and subsequently upgraded by Welsh Government to a Nationally Reportable Incident	0	0
Never Events	0	0

5. Complaints

Public Health Wales aims to manage complaints effectively and efficiently in a timely manner. There is a continuing focus on using information from all of the complaints that we receive as a mechanism to improve our services and functions.

Table 4 below summarises performance for managing formal complaints for 2022-23 compared to the previous year.

Table 4: Historical formal complaint performance

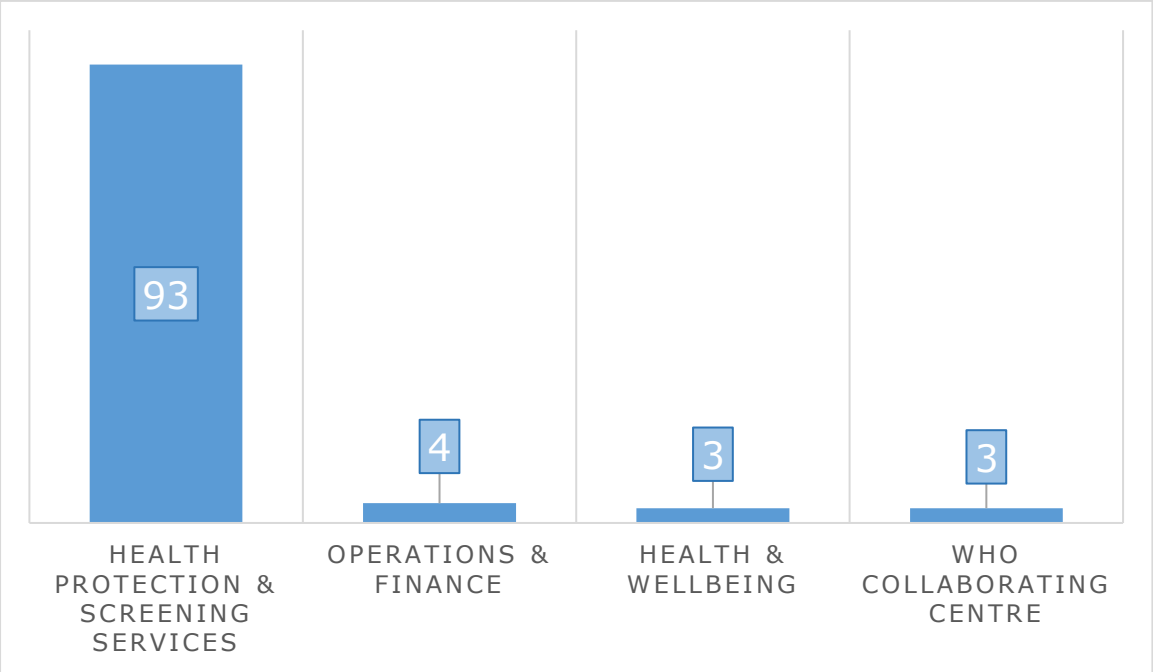
Formal Complaints	2021/22	2022/23
Total number of Formal Complaints	84	30
Acknowledged (**Target2 working days**)	77 (92%)	27 (90%)
Managed and responded to within 30 working days (**Target – 75%)**	73 (87%)	29 (97%)
Responded to within a period exceeding 30 days but within 6 months	10 (12%)	1 (3%)
Responded to within a period exceeding 6 months	1 (1%)	0

One complaint was responded to outside of the 30-working day timeframe as during the Executive Quality Assurance process, it was requested that amendments were made to the final response letter. This complaint response was sent on day 31.

Complaints by Directorate

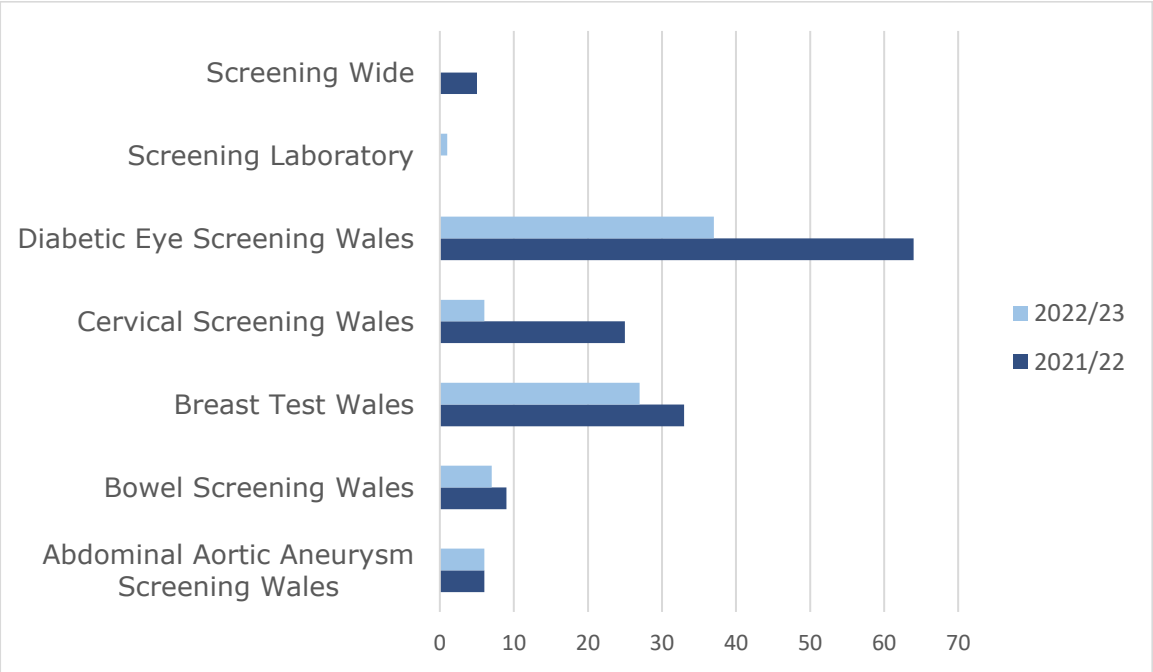
The graph below details complaints (including both Early Resolution and Formal) received in 2022/23. Health Protection and Screening directorate see the largest number of service user, so this is expected. This is also consistent with previous years.

Graph 3: Complaints by Directorate



The table below outlines complaints by Screening Division.

Graph 4: Complaint breakdown by Screening Division



Diabetic Eye Screening Wales received 37 complaints in 22/23 compared with 64 in 2021/22. This reduction would appear to correlate with the resumption of the screening programme following a pause during the

Covid-19 pandemic. With the recommencement of the programme and availability of venues there have been less complaints received in 2022/23.

Cervical Screening Wales have also seen a reduction in the number of complaints received this year with only 6 being received, compared with 25 in 2021/22. This higher number in the previous year was attributable to the to the extension period announcement for the Cervical Screening pathway from 3 to 5 years.

Complaints by Subject/Theme
The table below highlights complaint themes for both Formal and Early Resolution complaints received between 1 April 2022 to 31 March 2023.

Table 5: Formal and Informal complaint themes

Complaint Subject	Number of Complaints
Communication Issues	30
Appointments	29
Attitude and Behaviour	16
Clinical Treatment / Assessment	7
Equality	5
Record Keeping	4
Environment / Facilities	3
Access to Services	3
Confidentiality	2
Test and Investigation Results	2
Equipment	1
Patient Care	1

The most common complaint subjects are:

- *Communication Issues* – Some examples include issues with appointment letter and Welsh Language statements
- *Appointments* – Including dissatisfaction with appointment delays, locations, and cancellations.

Complaints by Outcome

Of the 103 complaints received in 2022/23, 56 (54%) were determined to be Upheld by the Investigator. 46 (45%) were deemed as Not Upheld by the Investigator and one 1 (1%) remains under investigation awaiting the outcome.

None of the complaints received in 2022/23 were re-opened following closure.

No complaints received in 2022/23 were referred to the Public Services Ombudsman for Wales.

5.1 Learning and Improvements from Complaints

All the complaints received provide an opportunity to identify learning and areas for improvement.

Below are some examples of learning and actions taken from Complaints received in 2022/23:

Dissatisfaction with the Welsh Language sentence required and included on all screening invitation letters.	•The concerns were reviewed by the Welsh Language and Public Information Groups and revised wording is now being considered for organisational roll-out.
A complaint was received about a screening clinic not opening on time. Staff were also waiting outside for the clinic to open due to rota confusion.	•Multiple rotas have been combined into a single rota so that it is clearer to see who is opening and closing each day. This action has also been implemented into other screening sites to prevent re-occurrence at another venue.
A complaint was received regarding the location and accessibility of a screening site that is not owned by PHW.	•Communication with service user has been improved to better prepare them for accessing the site. The site is managed by the local health board and their Estates Team are now working with us to improve signage and complete a new risk assessment for the venue.

6. Redress

Under the framework for investigating concerns, including patient safety incidents, there is an obligation on Public Health Wales, 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 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?

During the period of 1 April 2022 to 31 March 2023, Public Health Wales has received 4 Redress cases. This is a reduction of 1 from 5 received in the previous year.

Redress cases have been received in the following areas:

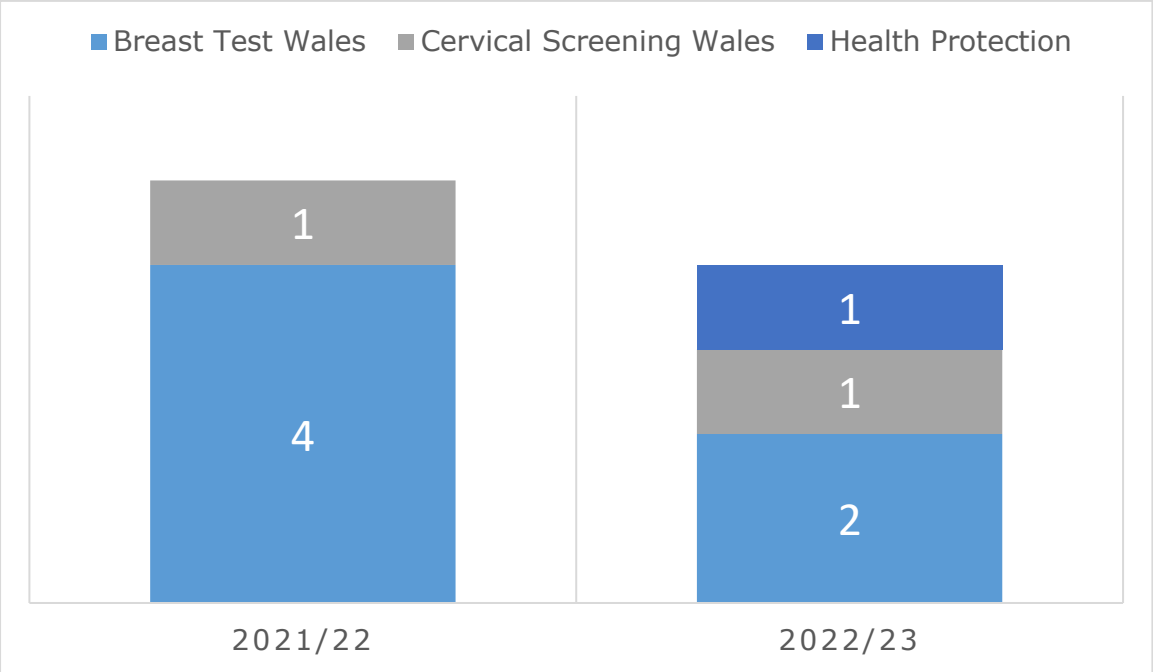
- Breast Test Wales (2)
- Cervical Screening Wales (1)
- Health Protection (1)

One of the Breast Test Wales cases and one Cervical Screening Wales case are now closed and the criteria for qualifying liability has not been met on either case.

One further Breast Test Wales case and a Health Protection case currently remain open and are under investigation with the support of the Claims Manager.

The below chart shows the areas where Redress cases have been received and a comparison with the number received in 2021/22.

Graph 5: Redress case breakdown



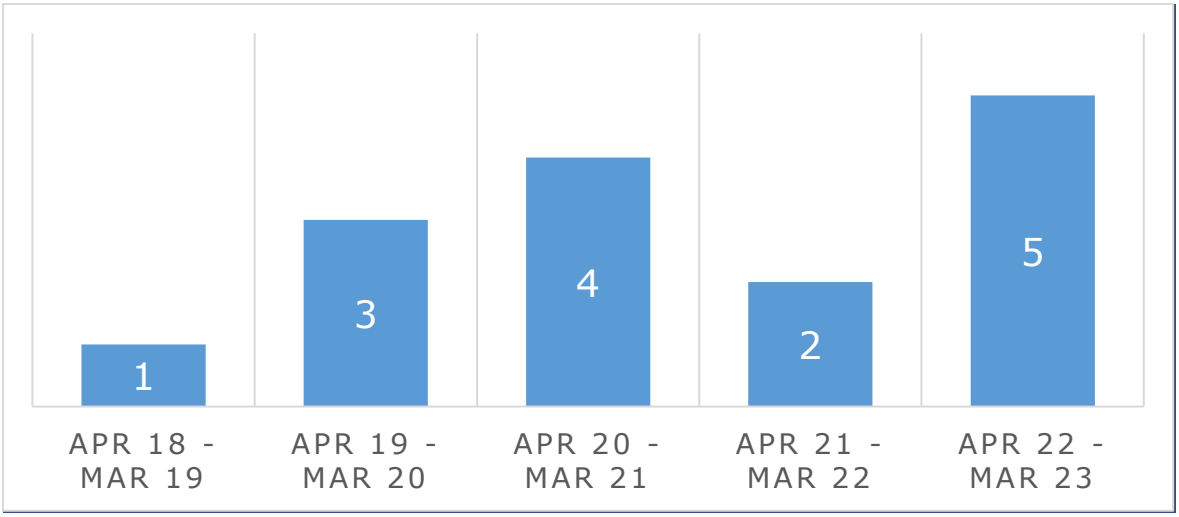
7. Claims

Public Health Wales has a relatively small claims profile. Claims are reported via Datix Cloud and managed by the Claims Manager with advice and support from Legal and Risk Services.

At the end of March 2023, there are currently 19 confirmed claims and 4 potential claims.

During the period of 1 April 2022 – 31 March 2023, Public Health Wales received 5 new claims. Three relating to Clinical Negligence and two relating to Personal Injury. This is an increase from 2 received in 2021/22.

Graph 6: Number of new claims



7.1 Learning from Events Reports (LFER)

As per Welsh Risk Pool requirements, a Learning from Events Report is submitted to Welsh Risk Pool within 60 working days of the decision to settle a claim.

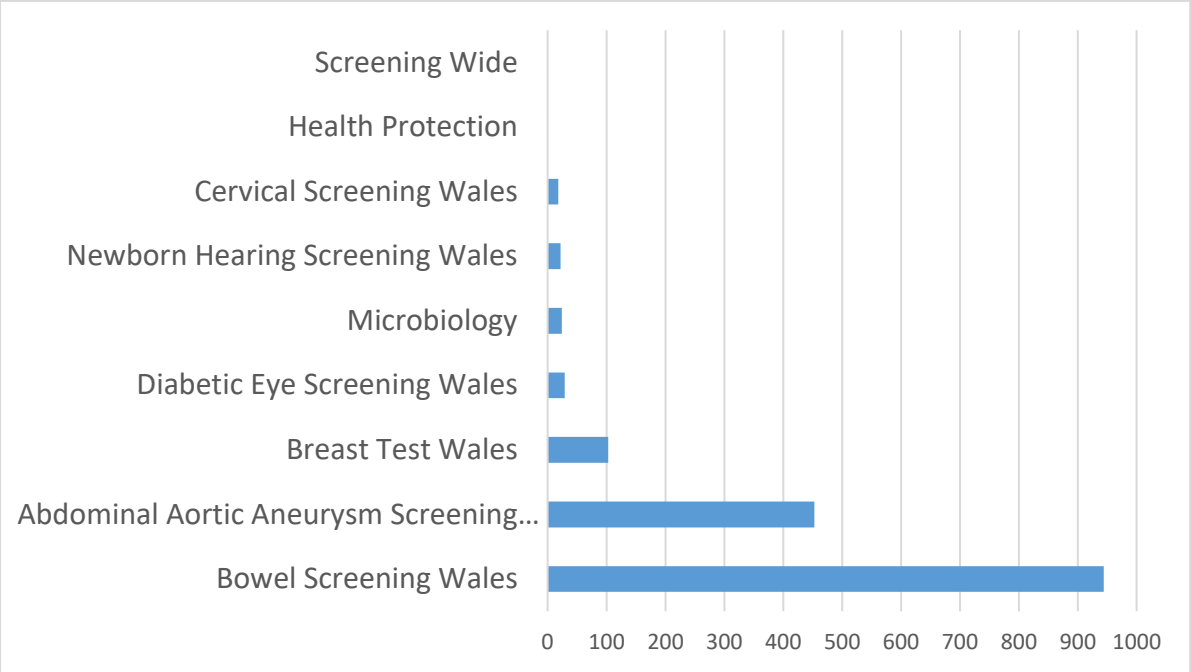
During the reporting period, 2 LFER's were submitted, outlining the learning from the claims presented and both were approved by the Welsh Risk Pool.

8. Compliments

In 2022-23, Public Health Wales received a total of 1,589 compliments. This is a decrease of 450 from 1,985 received in 2021/22. The transition to Civicia has led to areas of the organisation not reporting compliments on Civica who would have done so on Datix. This has been highlighted in an ongoing audit utilising six months of data in the Civica system. To improve the promotion and use of compliments for quality improvement, we have developed an organisational definition of a compliment and we will be using the findings of the audit to engage and work with teams across Public Health Wales.

1,585 of these compliments were received by the Health Protection & Screening Services as the largest direct service user contact directorate. The graph below shows the breakdown of compliments by area within Health Protection & Screening Services.

Graph 7: Breakdown of compliments by area



Other areas of the organisation that received compliments in 2022/23 are:

- Improvement Cymru (3)
- Quality, Nursing & Allied Health Professionals - Service User Experience (1)

The top three themes of compliments received are as follows:

- Beyond the level of care expected
- Positive attitude/behaviour of staff
- Professionalism of staff

9. Successes and Challenges

Just some of the successes achieved in this year are outlined below;

- Successfully implementing the Datix Cloud IQ Concerns Management System across the organisation on 1 April 2022.

- Developed comprehensive training packages and guides for staff members on how to report and investigate incidents and complaints.

- Collaborative working with Datix Super users across the organisation on a monthly basis to discuss Datix updates and incident and complaint management.

- Introduced Quality Reviews to the Datix System to review and audit incident records to ensure that lessons are learned, and actions are taken following incidents, as well supporting staff with best practice use of Datix.

10. Looking ahead for 2023/24

Our focus for the coming year will be to:

- Align Putting Things Right within the organisational system mapping of Quality as an organisational strategy.

- Introduce Quality Reviews for Complaints to ensure we identify learning from all complaints received and embed a culture of learning.

- Continue to work closely with Directorates across the organisation and develop bespoke training packages to meet all needs and improve performance and quality of incident management.

- Work with Engagement colleagues to ensure that service user experience is as accessible as possible to service users and triangulate data from service user experience to support with Quality improvements and wider learning.

11. Recommendation

The Quality, Safety and Improvement Committee is asked to:

- Note and take **assurance** on the Putting Things Right Annual Report for 2022/23