GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Putting Things Right

Concerns, Compliments Claims and Redress cases for 2019-20

Contents

Introduction

The Putting Things Right Annual Report provides information on the progress and performance of Cardiff and Vale University Health Board in their management of concerns during 2019-2020. This report includes compensation claims management.

The Report is prepared in line with 'The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011', of which Regulation 51 provides that a responsible body must prepare an annual report.

Focus of Report:

Concerns - Redress - Claims - Trends, Themes and Lessons learnt - Compliments

Background

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (hereafter, the 'Regulations') apply to all Welsh NHS bodies, primary care providers and independent providers in Wales, providing NHS funded care and were introduced in April 2011. The Regulations set out the process for the management of concerns and is known as Putting Things Right (PTR). The Regulations are supported by detailed guidance on raising a concern. The process:

- Aims to make it easier for people to raise concerns; to be engaged and supported during the process; to be dealt with openly and honestly; and for bodies to demonstrate learning from when things went wrong or standards needed to improve.

- Introduced a single more integrated approach, bringing together the management of complaints, incidents and claims, based on the principle of 'investigate once, investigate well'.

- The process is underpinned by a comprehensive set of regulations and supporting guidance.

  As a Health Board we are committed to listening to people who use our services, resolving their concerns where possible in a proportionate and empathetic manner. We aim to provide an effective and timely process for responding to concerns, which enables the Health Board to improve services based on lessons learnt, with the aim of achieving high quality, compassionate and effective care for all service users, whether in provided or commissioned services.

Arrangements in place for Managing Concerns

All concerns are reviewed by the Executive Nurse Director and the Assistant Director of Patient Experience and graded dependent on the seriousness of the complaint. This indicates the level of investigation required, e.g. a full Root Cause Analysis Investigation, Informal Investigation, which we aim to resolve within 2 to 5 working days, or a Formal 30 day Investigation.

Concerns are shared with the Directors of Nursing within the relevant Clinical Board, following which an Investigating Officer is appointed. It is good practice for the Investigating Officer to make contact with the Complainant.

Under the Putting Things Right Regulations, all Formal Concerns have to be acknowledged within 2 working days. The Concerns Team agree the Terms of Reference with the Complainant and provide the Investigating Officer with the specific questions to be investigated as agreed with the person raising the concern. This helps to ensure a comprehensive response is provided. In our ongoing evaluation of the concerns service this initial contact and listening to people has been appreciated. We encourage personal contact with each Complainant to ensure that we acknowledge their correspondence in a more empathetic and personal manner than just formally writing to them.

For those investigations that require further time, the Concerns Team contacts the Complainant, prior to the 30 day target, to explain the reason for the delay and advise that further time is needed. Early Resolution, where appropriate is encouraged.

Within the response, Complainants are offered the opportunity to meet with the Health Board Staff. As part of the regulations, there is an obligation on a Welsh NHS body to consider when it is notified of a concern that alleges harm or may have been caused, whether or not there is a qualifying liability. This is included in the response, along with the advice on how concerns can be forwarded to the Ombudsman

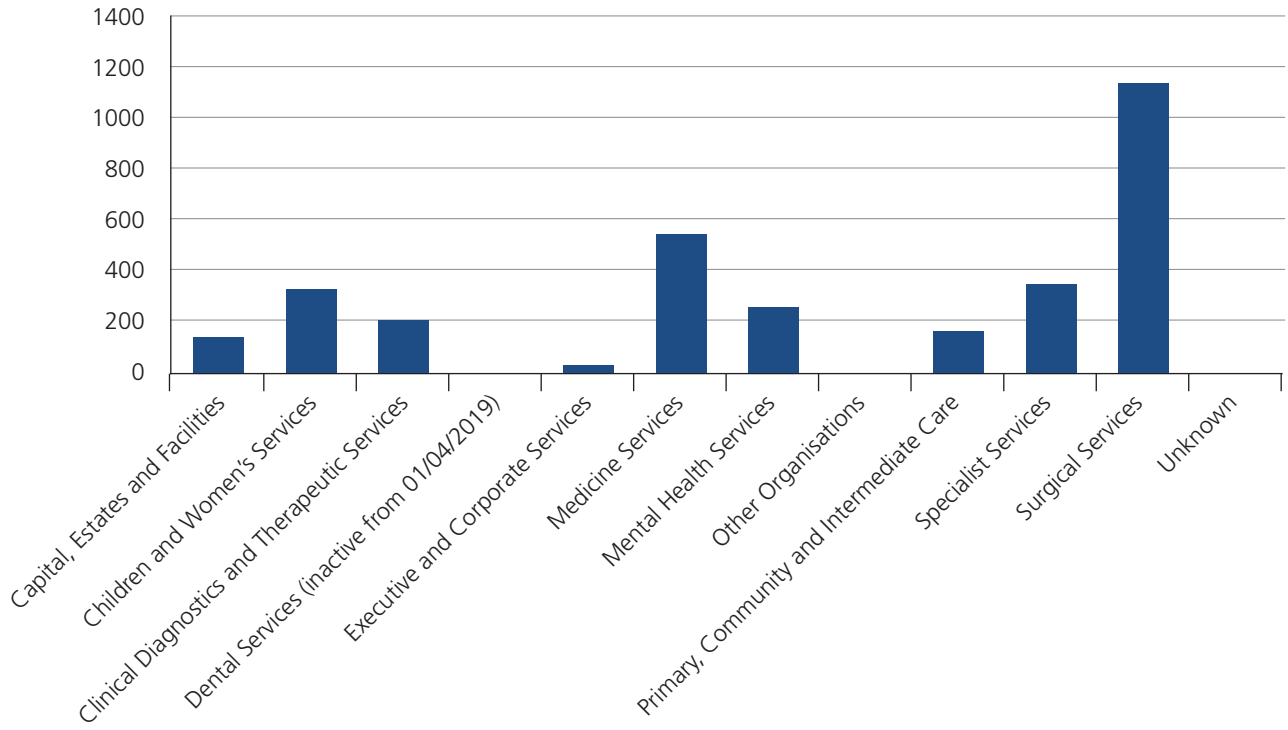
Overview of 2019-20	**2018/19**	**2019/20**
Concerns	2,759	3,166
Closed under Early Resolution	717	590
Active Redress Case	47	48
Redress cases closed	36	36
Redress to Clinical Negligence claims	36	33
Clinical negligence Claims	80	102
Personal Injury Claims	53	44

How did we do?

Concerns	2018/19	2019/20
Acknowledged in 2 working days	98%	98%
Managed and responded to within 30 working days against a target of 75%	87%	84%
Early Resolution (within 2 days including day of receipt)	717	590

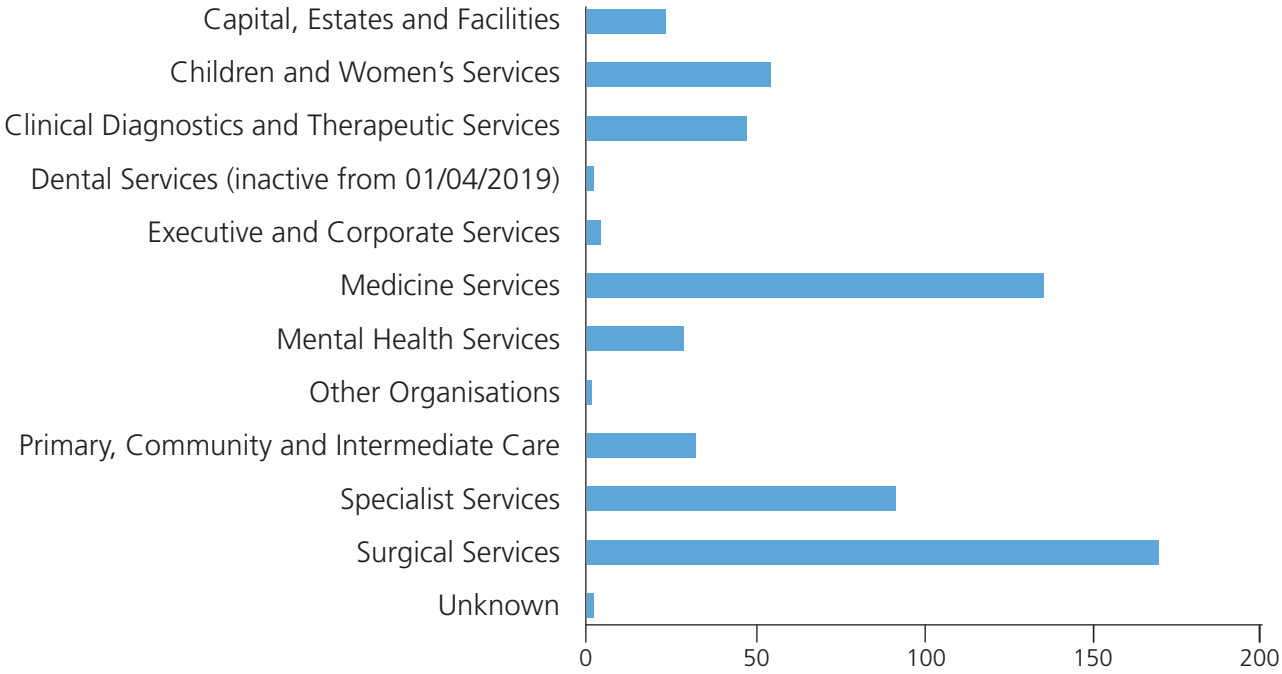
Concerns Statistics

Concerns - All Received by Clinical Board 1/4/2019 to 31/3/2020



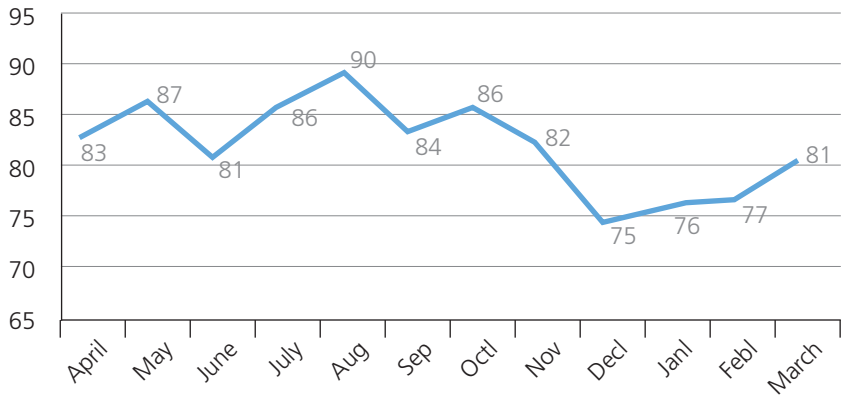
In 2019/20 we received 3166 concerns, 590 were managed under early resolution, providing a satisfactory outcome to the person raising concerns within 2 working days (including day of receipt)

Early Resolution



One of the aims for the Concerns Team for 2019/20 was to maintain key working relationships with Clinical Boards and to sustain a 30 working day response time of 80% across the Health Board. Throughout the year the performance was consistently above the Welsh Government target of 75% and exceeded our internal target of 80%.

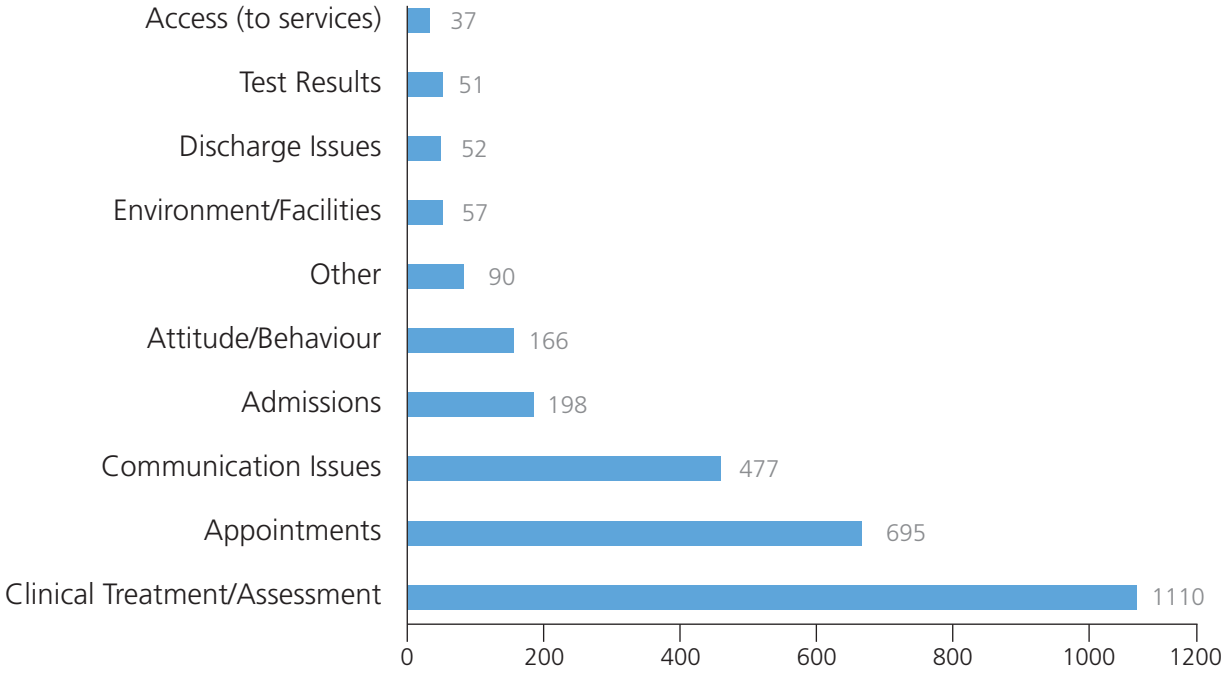
Table demonstrating 30 working day response performance time



Themes

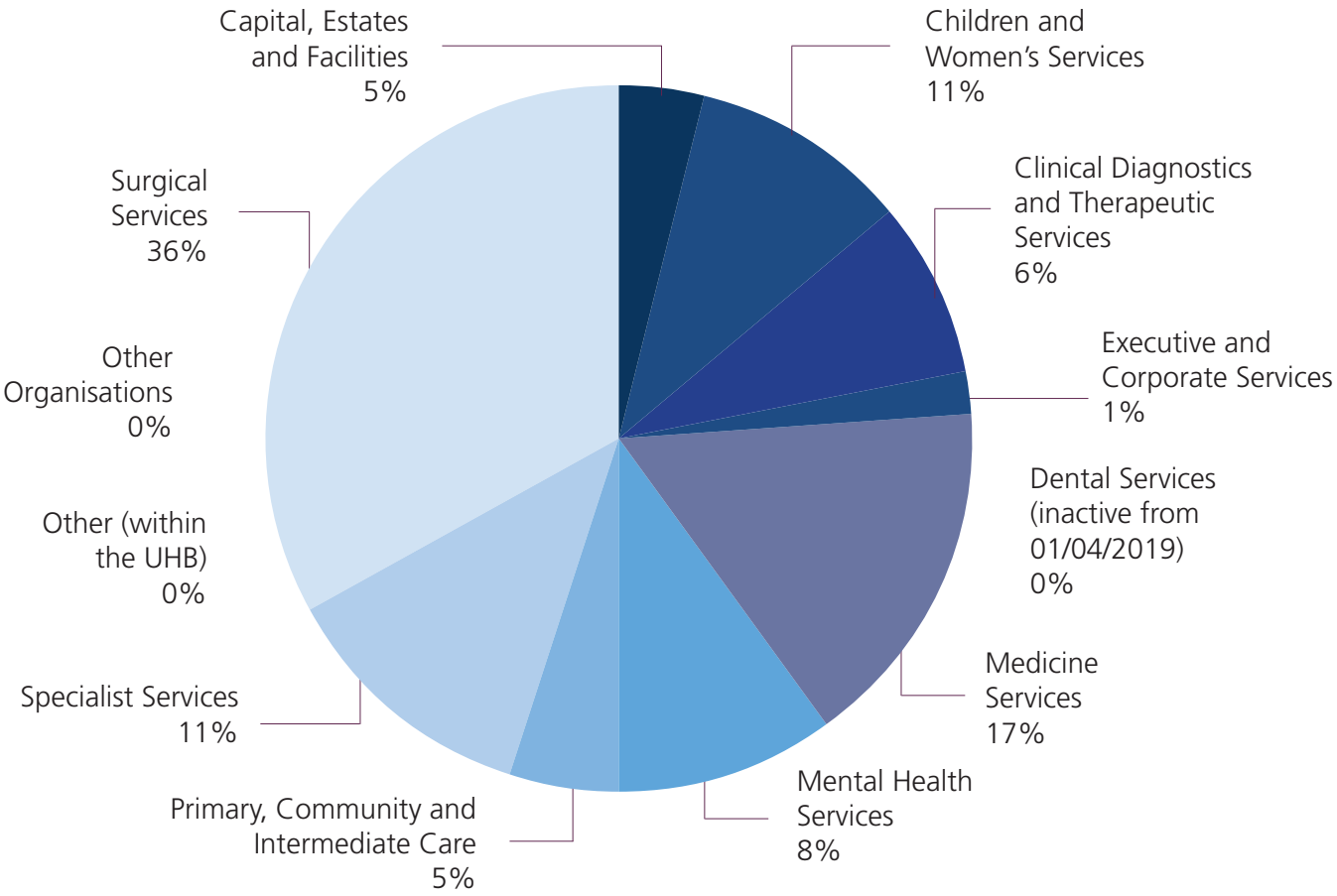
The highest number of concerns relate to clinical diagnosis and treatment followed by waiting time for appointments.

Top 10 Subject 1/4/19 to 31/3/2020



Some data re Clinical Boards:

Concerns - All Received by Clinical Board



As you will note from the above Surgery Clinical Board received a significantly higher volume of concerns than other Clinical Boards. A high percentage of concerns received during this period related to delay/cancellations in Ophthalmology Outpatient Appointments.

A number of actions have been taken to address the rise in cancellations and delays.

Unfortunately, it has been recognised that the delays in Ophthamology are unacceptable and investigations are ongoing to establish if patients have come to any harm as a result. There were also a high number of concerns raised relating to treatment provided by an Insourcing Team commissioned by Cardiff and Vale UHB and Investigations concluded that there were failures in care, however, due to the potential value, they were taken out of Redress and Complainants were advised, that it would be in their best interest to obtain legal advice with regard to pursuing a Claim

A number of actions have been agreed to address the issues raised relating to cancellations of appointments and loss to follow up including:

- Ophthalmology Department will arrange additional sessions to clear all new patient referrals waiting over 5 weeks or more.
- Consultant Ophthalmologist will draft acceptance criteria to manage new patient referrals including out of area boundaries.
- Ophthalmology Directorate will review the commissioning arrangements for out of area boundaries.
- Ophthalmology Service Manager and Deputy Health Records Manager will meet weekly to agree where referrals should be sent to ensure there are no delays and list urgent patients as necessary.
- Ophthalmology Service Manager and Deputy Health Records Manager will meet to agree the information accessible to the Appointment Booking Centre is accurate.
- Changes will be made to the PMS to allow staff in Health Records to input a target date for new patients.
- The Ophthalmology Directorate Management structure will be reviewed to ensure that there is sufficient capacity to undertake the additional responsibilities associated with the monitoring and management of follow-up patients that have breached their target date.

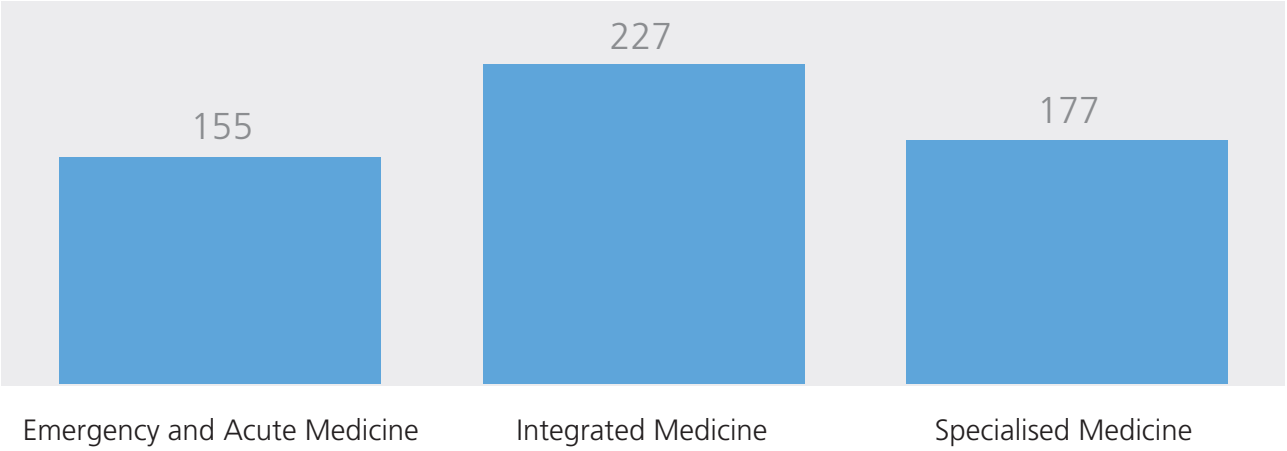
Medicine Concerns

Medicine Clinical Board received 547 Concerns during this period and as you will see from the graph below, Integrated Medicine received the highest number of concerns. This reflects the high number of contacts within this Directorate and the complex nature and long term ongoing care these patients require. These concerns are often multi-faceted and involve aspects of care related to other Clinical Boards due to Joint Care. Nursing and documentation is raised in a high number of more complex concerns.

Hopefully this will be addressed through the introduction of the All Wales Electronic Nursing Documentation.

It should be noted that EU receive the highest number of Compliments across the UHB.

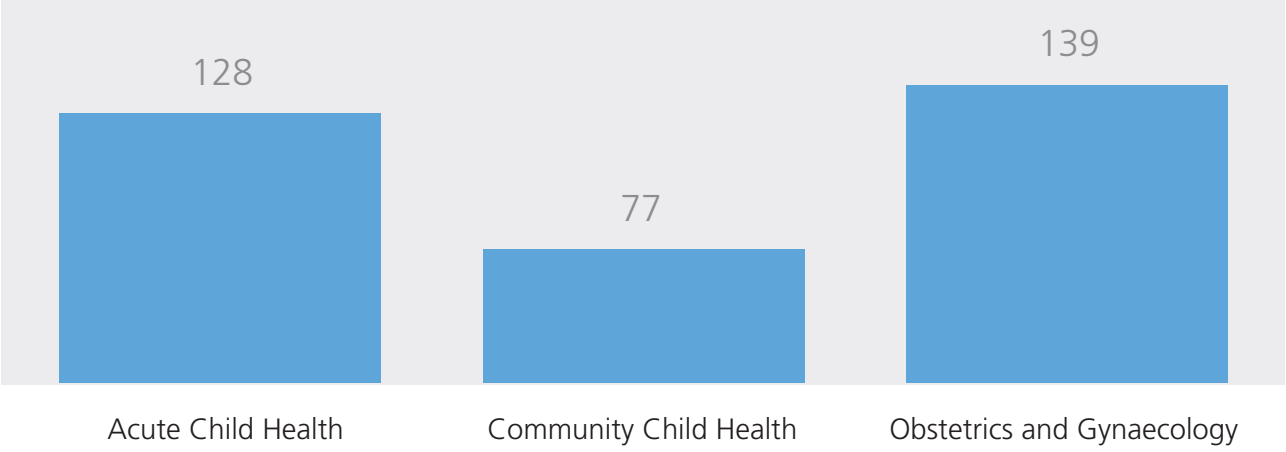
Medicine Complaints by Directorate



Children and Women Clinical Board

Children and Women Clinical Board received 344 concerns during this period and the highest number raised were logged by the Obstetrics and Gynaecology Directorate. Following the Cwm Taf report into Maternity, we received several concerns relating to patient's not being happy with their birthing experience and historic care provided, some 10 years previously during Labour. Evidentially practice and guidance has changed since this care was provided. Patients who have experienced a miscarriage have also highlighted that they do not feel they are being treated timely and there is a lack of empathy and consideration. We also have a number of cases being reviewed by Independent External Experts in relation to the care provided to children prior to their death. We are hoping this will provide parents with an independent view.

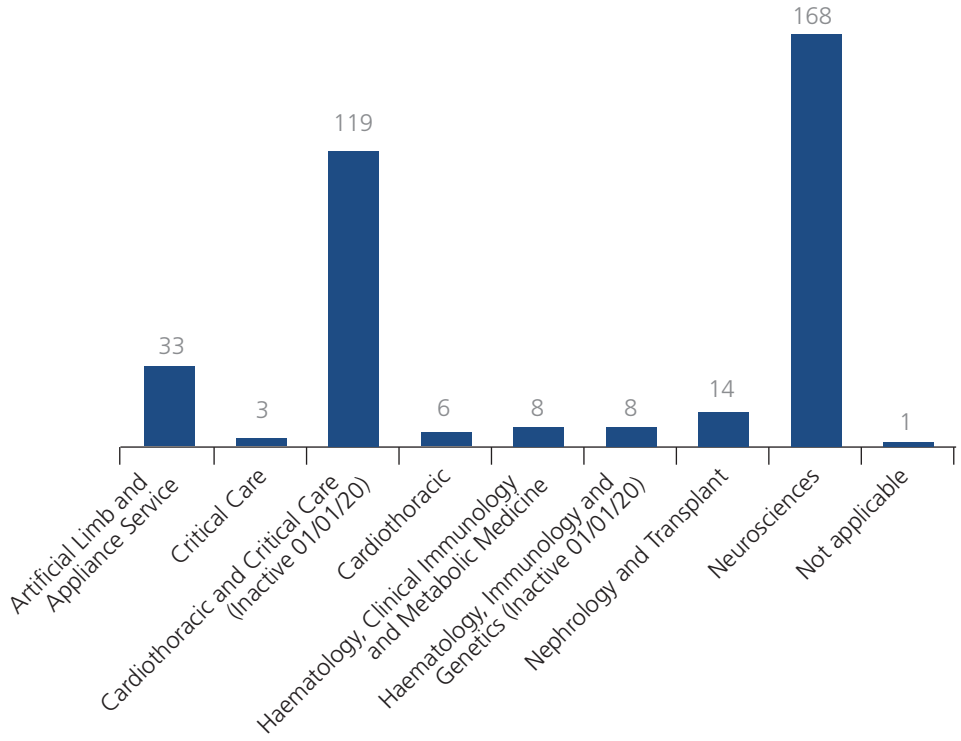
Children and Women Concerns by Directorate



Specialist Services

Specialist Services Clinical Board received 360 concerns during this period and over 50% of these were logged under Neurosciences. We received a number of concerns related to complications arising from Neuro Surgery and possible equipment failure, however, upon investigation, none of these cases were deemed as a result of substandard treatment and equipment failure where identified was not foreseeable. Consent was also highlighted as an issue as, whilst the complications experienced were very low risk and would not usually have formed part of the consenting process, it was considered that, in light of Montgomery, the risks were life changing and should have been discussed.

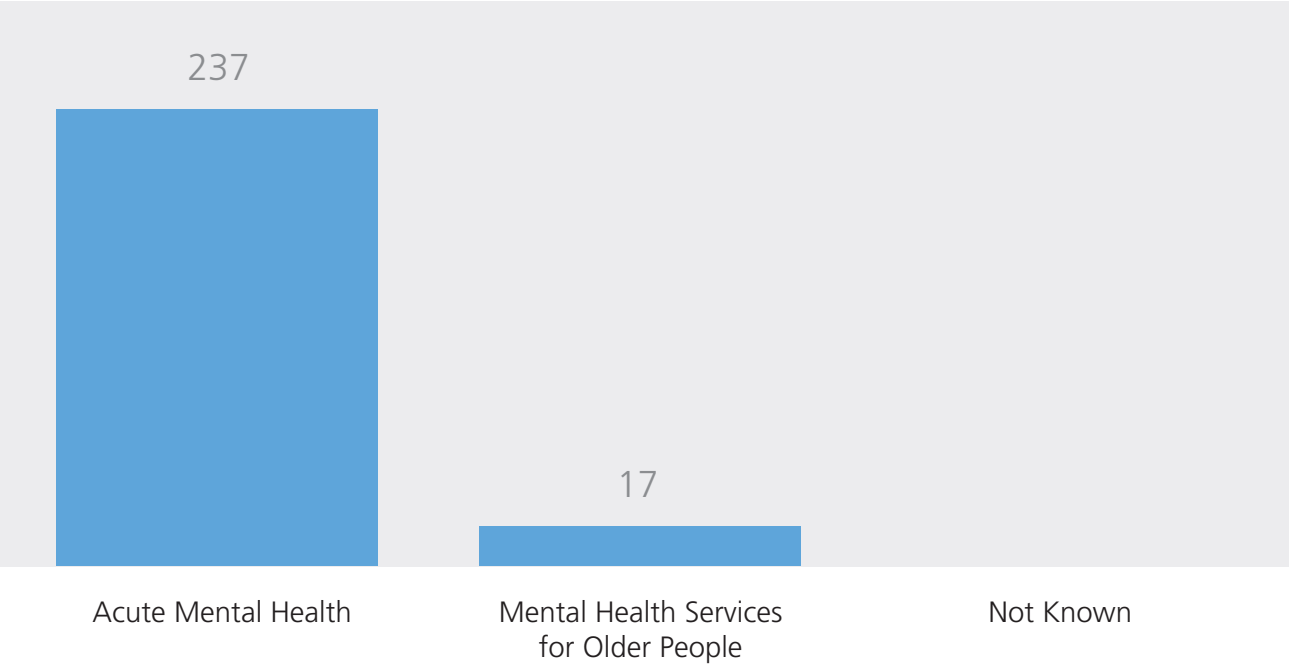
Specialist Services by Complaints by Directorate



Mental Health

Mental Health Clinical Board received 255 concerns during this period and the majority of these concerns were logged with Adult Mental Health. We received a high number of concerns relating to patients who committed Suicide whilst seeking or receiving treatment from Mental Health Services. A number of RCA investigations and improvement/action plans have been implemented.

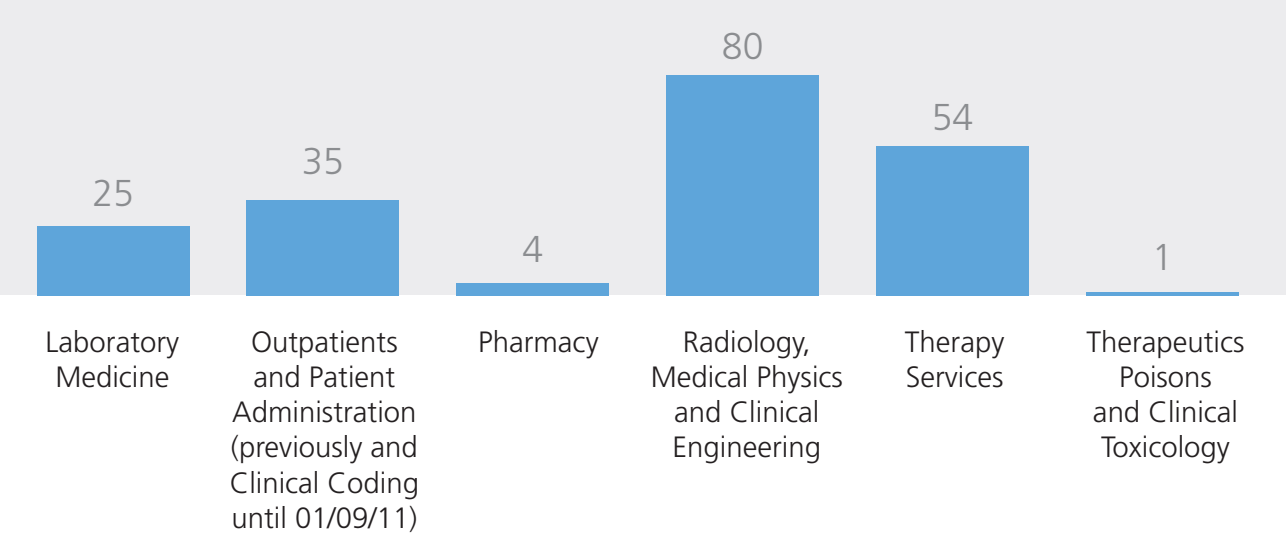
Mental Health Complaints by Directorate



Clinical Diagnostics and Therapies (CD&T)

CD&T Clinical Board received 199 concerns during this period. Radiology received the highest number of concerns relating to delay in appointments and Radiology reporting. CD&T are actively monitoring the Radiology reporting turnaround time on a weekly basis and have requested that the Radiology Directorate provide the process for addressing any backlog. Since the cancellation of charges for patient records, we have noted an increase in concerns relating to the delay in providing records.

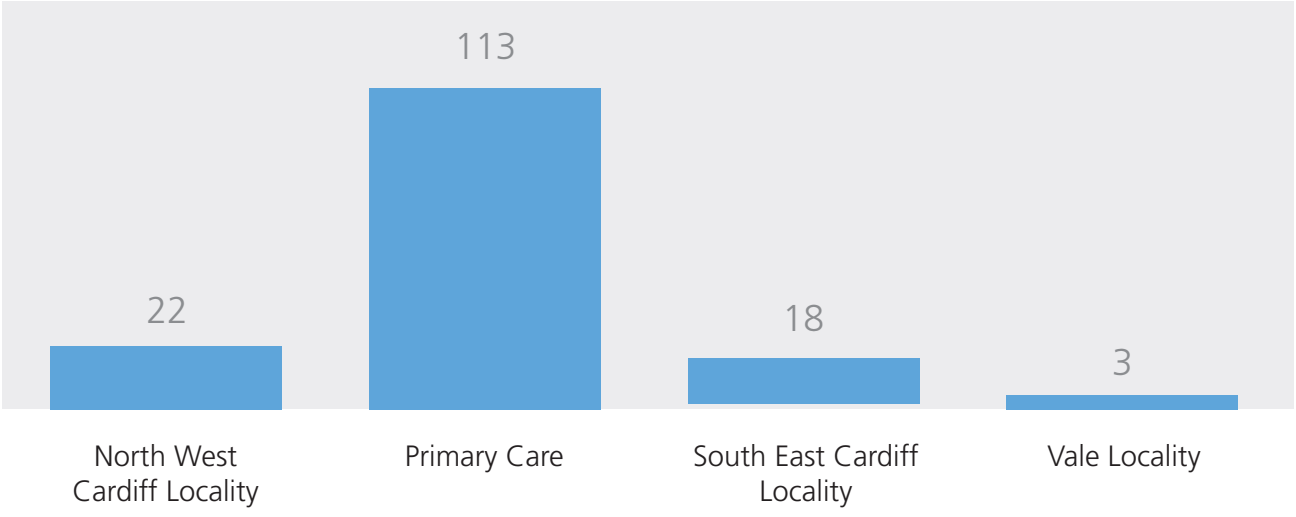
CD&T Complaints by Directorate



Primary, Community and Intermediate Care (PCIC)

PCIC received 158 concerns during this period. The majority of the concerns raised were logged with Primary Care, which covers the GP out of Hours Service and Independent Contractor's. Themes noted in concerns relating to GP's is attitude of staff, however, these concerns are redirected to the Practice to respond. Attitude of Out Of Hours Doctors has also been noted as a recurring theme. Doctors have been asked to listen to calls and reflect on their interactions.

PCIC Complaints by Directorate



Learning from Concerns

All complaints and patient feedback provide us with an opportunity to make changes to improve the services and Patient Experience. The following are examples of action that the UHB has taken following concerns raised by patients and their families in the previous year: the feedback from our Complainants is that they like the use of "You said-We Did" to convey the actions taken:

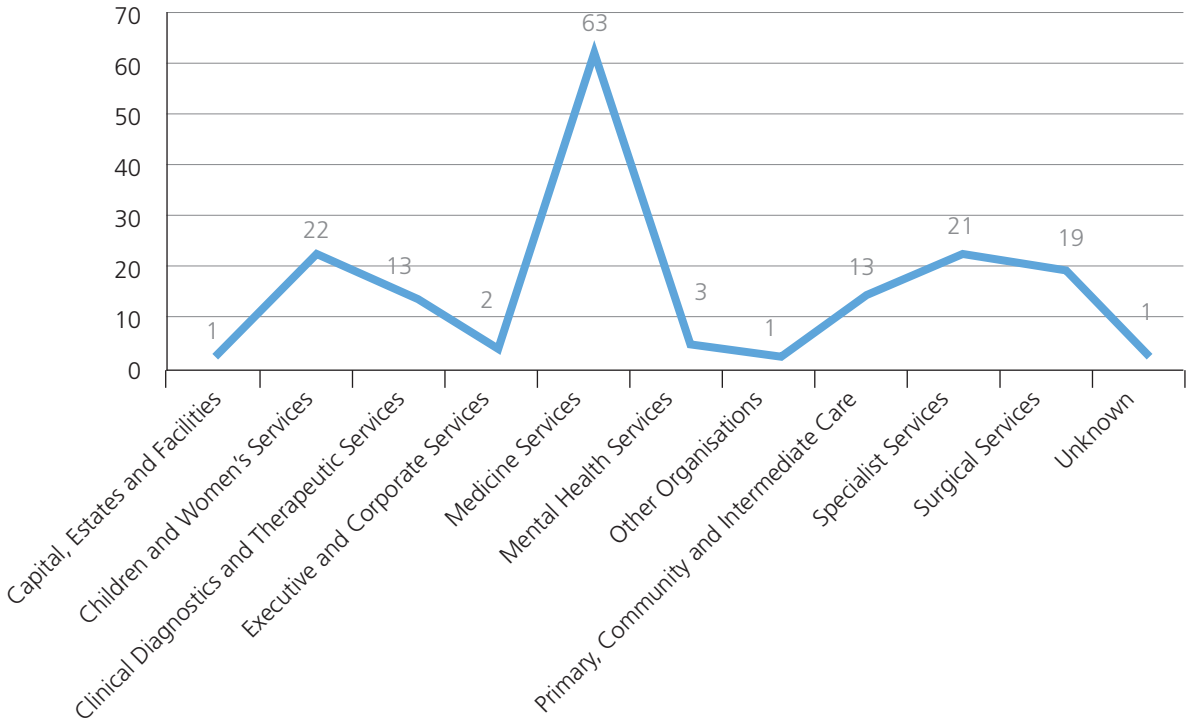
You said	We did
Wording used in regards to Mental Health Assessment misleading and unclear.	Wording being reviewed to ensure accuracy and also to be more helpful in tone.
Complex Pathology opinion sought from C&V Whilst Pathologist on A/L therefore a timely Opinion was not provided	No other expert within Wales to undertake an expert opinion, therefore, it is now agreed that any expert opinion cases received will be returned to sender indicating that expert opinion needs to be sought in England or North America.
Why was I not given any advice on how to look after a central line when my daughter was discharged?	A going home pack that will be accessible on Pelican Ward for children going home, out of hours, with a central line in situ. The pack will contain all the necessary items for the care of a central line. The current information sheet will be updated; it will have pictures of the central line and more details of what to do in emergencies.
I was not offered any transport option when I required an urgent assessment at the GP out of Hours clinic	For patients who require an urgent assessment; the OOH service will discuss all other avenues for transport with patients before exploring the Taxi Protocol further. This includes discussing; public transport, friends, and relatives or neighbours that may be able to offer support with travelling provisions. The Taxi Policy will be re-circulated to all clinicians working for the service to re-familiarise themselves with this process.
Concerns raised relating to the Concerns Team Phone Lines being busy which resulted in a caller having to complete a concerns form.	Additional phone numbers added to the website to maximise capacity to manage telephone enquiries in a timely manner. Additional information added to recorded message on UHW Switchboard to transfer calls directly to Concerns.

You said	We did
Concerns raised regarding test results being given to a pt confirming diagnosis of cancer and a pathologist re-reviewed it at MDT and it was reclassified as not cancer	Consultants will now mention the potential for results change (although this is rare) at the diagnosis clinic in order to avoid this situation again. Word of caution to be added: 'The final results of pathology and scans will be reviewed by the multidisciplinary team and confirmed with you at the consultant clinic
Patient presented several times with suspected ruptured membranes but was repeatedly told that her waters had not	Midwives have been reminded to seek an obstetric review if patients present repeatedly and feel that their waters have broken.
Laminated cleaning sign on toilets not kept up to date	These have been replaced

Compliments

The Graph Below clearly shows that Medicine Clinical Board receive the highest number of compliments, with the majority being recorded with the Emergency Unit – this is consistent with previous years. It is appreciated that number of recorded complements remains low but we are aware that many compliments are received via social media. It is anticipated that the All Wales Patient Experience System once in place will enable capture more easily of compliments via social media feeds.

Compliments received by Clinical Board



Compliments

Many thanks to everybody. Really, my treatment was absolutely the Rolls Royce of Surgical, Nursing and Medical care. Thank you UHW.

All nursing staff, health care support workers and catering staff showed nothing but compassion and professionalism at all times. As a young adult with little experience of hospitals, an inpatient stay can often be very frightening, but thanks to the kindness of your staff this fear soon changed to trust and confidence in the care she was receiving.

This unit is exceptional in their operation. Everything runs like clockwork, I was amazed at how well it was run, but not only that, every member of the nursing team were so friendly and caring. They made time for you. They seemed such a happy team. Nothing was too much trouble and they kept constant check on me.

Compliments

The heart attack and recovery was a major event, but thanks to the dedication of the staff, I managed to recover in a safe and friendly atmosphere, and was able to let go of a lot of fear because I trusted that I was under the very best possible care. I place a lot of my recovery on the standard of care that I received, and it was care, not just nursing, but the staff at all levels genuinely did care about every patient, this is shown by the conversations that staff had with patients, they really took an interest in each person. The CCU is a place where there are constant beeps and call buttons, but it is also safe, warm and friendly. The friendliness of staff with patients and indeed visitors only enhances the level of care provided.

Redress:

A case moves into redress if we identify that there is or maybe a qualifying liability i.e. we have identified in breach in our duty of care and we know the patient suffered harm because of the breach or we need to investigate further to establish if harm was caused

Where the investigation of a concern concludes there has been a breach of duty the case is presented to the **Putting Things Right Redress Panel.**

The Panel are required to consider whether redress applies in situations where a patient may have been harmed and the harm was caused during care provided by the health board.

Redress can be the giving of an explanation, a written apology, the offer of financial compensation and / or remedial treatment, on the understanding that the person will not pursue the same through civil proceedings.

The redress panel consists of:

- Assistant Director of Patient Experience (Chair)
- Assistant Medical Director
- Head of Concerns and Claims
- Redress Manager
- Redress Leads

The Panel holds a weekly drop in Clinic, this is open to all staff across the Health Board. Members of the Patient Safety Team, Investigating Officers and Clinical Board Staff are given the opportunity to discuss cases and obtain advice on Breach of Duty and discuss possible forms of Redress. Staff also attend for Learning and development.

There are currently 48 open Redress cases:

36 Redress cases were closed during this period.

- All ophthalmology cases as discussed previously were initially considered under redress
- The lack of investigations undertaken in the Emergency Unit resulting in patients being discharged and readmitted or requiring treatment at a later date.

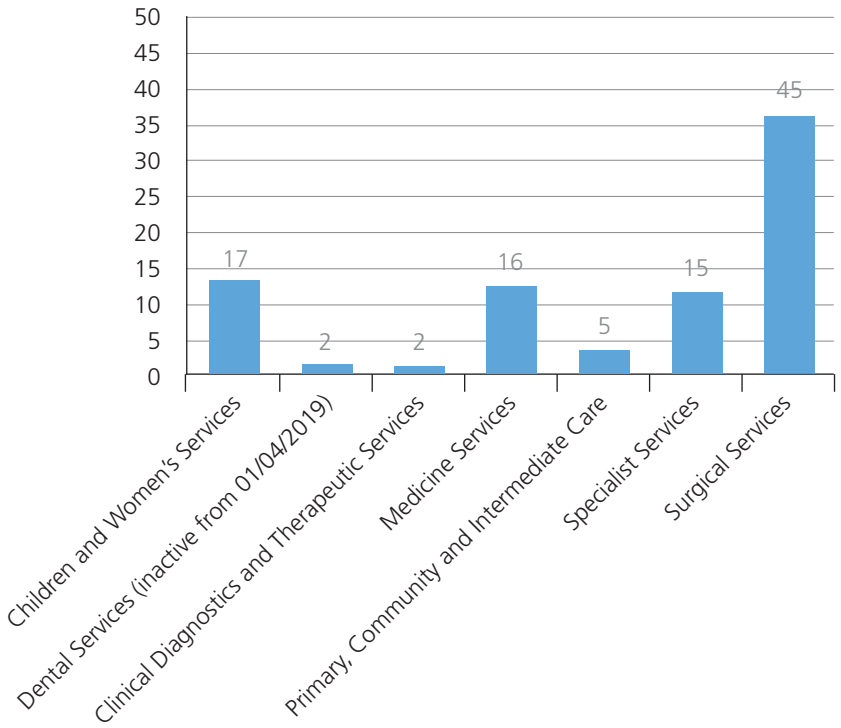
Learning Identified through Redress:

Case	Action/Learning
A young baby was given 10 times the amount of oramorph due to a prescribing error on a busy emergency ward.	Quiet Prescribing Area Identified and all clinicians encouraged to use this. Access to on-line BNF for Children provided in this area.
Patient was admitted for complex elective surgery. During surgery a swab was retained.	It was identified during the investigation that there was no clear guidance in the policy for the disposal of swabs during the counting process. The Policy and Procedure for the Swab and instrument count was reviewed and is in the process of being implemented.

Claims 01/04/2019 to 31/03/2020:

During this period, the Health Board has received 102 Clinical Negligence Claims, in comparison to 80 new claims opened during the same period last year which represent an increase of 19%. Surgery Clinical Board received 45 in total, followed by Medicine Clinical Board with 16.

Claims by Clinical Board 1/4/2019 to 31/3/2020



Top 3 categories identified in new Clinical Negligence Claims:

- Failure to diagnose and treat – 16
- Failure to properly monitor treatment – 11
- Sub-standard Surgical Technique -10

The main categories of claims are surgery and clinical treatment. In both these categories the overriding themes relate to individual clinical decision making or human error. In many of these cases there is already formal procedures, MDTs or NICE guidance that assists in ensuring that correct decision are made. However, where such individual errors are made, clinicians will reflect on their practice that may be discussed by peer review, revalidation or during their profession developmental plan. The Clinical Board's routinely discuss such cases at Quality, Safety and Experience or Audit meetings or specific clinicians have selected cases for review and for teaching purposes with their teams.

As previously mentioned a secondary theme in many cases often surrounds consenting issues; this is being driven by Claimant Solicitors since the case of Montgomery and will remain an additional allegation bought in many claims. The Health Board has been active in undertaking training in Consent and in assisting in the All Wales Review of consent processes

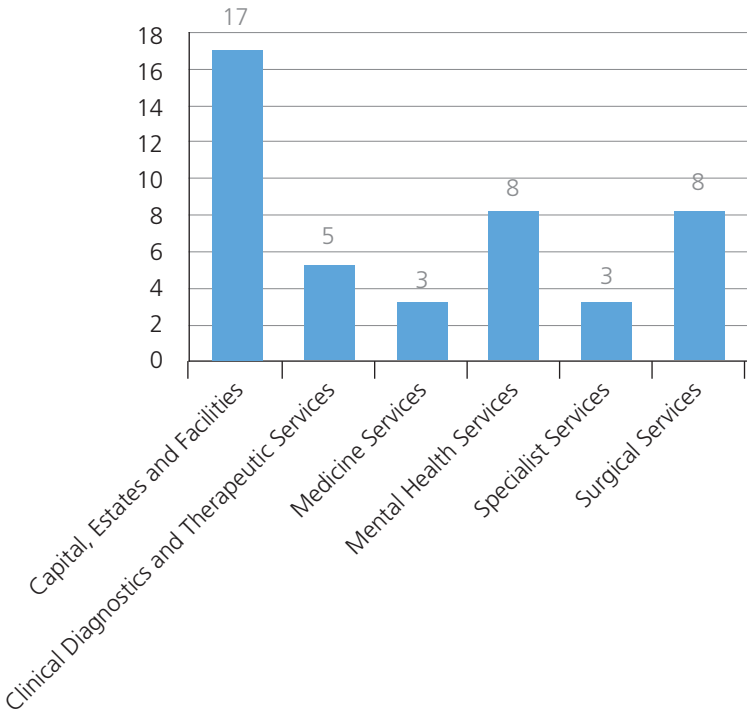
Falls

Injurious in patient falls remains a theme in redress and claims case. There is significant work being undertaken with regular updates provided by the Executive Director of Therapies to the QSE committee

Personal Injury Claims:

The Health Board received 44 personal Injury Claims, which is a slight decrease from last year (53) opened during this period.

PI Claims by Clin Board 01/04/2019 TO 31/03/2020



The highest number of new PI claims, 17 in total, were logged under Capital Estates and Facilities, followed by 8 in Mental Health Clinical Board.

The top three subjects identified were:

- Needle stick/sharps 9
- Behaviour/Violence - intentional injury 6
- Trip 6

Comprehensive reviews of PI claims and action being taken are shared via the Health and Safety group and Legal and risk provide a comprehensive report twice a year where the data is analyses and compared across Wales.

Ombudsman:

During 2019/20 the Health Board closed 3041 Concerns, of which **100** (3%) concerns were referred to the Public service Ombudsman for Wales and he chose to investigate **29** concerns, less than 1% of the Concerns responded to during the year. In that time period 12 concerns were upheld in whole or in part. No public interest reports were issued.

In June 2020, the PSOW published - Delivering Justice -
The Public Services Ombudsman for Wales **Annual Report and Accounts 2019/20**.
The annual letters will follow later in the summer with more detail in relation to Cardiff and Vale UHB and a report will be provided to the Quality, Safety and Experience Committee.

The table below presents a detailed comparison of new complaints about bodies compared to 2018/19:

Health Board	2019/20	2018/19	% change
Aneurin Bevan University Health Board	140	134	+4.5%
Betsi Cadwaladr University Health Board	227	194	+17.0%
Cardiff and Vale University Health Board	**100**	**102**	**-2.0%**
Cwm Taf Morgannwg University Health Board*	80	75	+6.7%
Hywel Dda University Health Board	92	109	-15.6%
Powys Teaching Health Board	23	26	-11.5%
Swansea Bay University Health Board*	91	139	-34.5%
Totals:	**753**	**779**	**-3.3%**

It should be noted that the numbers of concerns received in the Health Board overall increased from 2,759 in 2018/19 to 3,228 in 2019/20. Therefore we are pleased to note the percentage decrease from 3.6 % in 2018/19 of complainants who contacted the Ombudsman has decreased to 3% in 2019/20 despite the increased numbers

The Successes and Challenges across the Health Board 2019/20

Challenges

An important part of the Redress Regulations for the Health Boards in Wales is ensuring that lessons are learnt and actions taken as a result of any identified failings in care. On completion of each Redress case, i.e. once costs and damages have been paid, Appendix T forms are submitted to the Welsh Government (Welsh Risk Pool with effect from July 2018) for financial reimbursement to the UHB. The main focus of these forms is to identify these lessons learnt and actions taken for each case that has been investigated.

From October 2019 the Welsh Risk Pool (WRP) decided to change their reimbursement process

The purpose of the revision of the procedures is

1 To align all the various WRP procedures into one system.
2 To introduce a process where there is learning being introduced at the time of the incident.
3 To provide earlier scrutiny and evidence of the learning. In September 2019 the UHB was informed that the scheme would be brought into effect from October 1st 2019 and that it had to be applied to retrospective cases.

As a Health Board we were supportive of the concept and the desire to promote learning as soon as possible in the process to minimize the risk of a reoccurrence of an incident. However, implementation of the new process was a challenge as it applied to the entire active caseload of redress and claims cases. This meant completion of the 245 learning from events forms whilst being mindful of other triggers for financial reimbursement.

This new process also places a pressure upon the clinical boards as they complete the new documentation at the most pressured time of the year from an activity perspective.
The financial implications of not completing the forms could have meant failure to reimburse the entire case.

We took some action to try to manage the risk

- We worked on identifying themes in any clusters of cases and producing joint learning plans -however this mainly applies to low value cases rather than our high value
- We established a process for identifying the 2 trigger points
- We triaged and ensured that we considered high value cases first

- We engaged with clinical boards around clusters of cases in focused meetings
- We maintained a shared library of evidence
- We have completed the review of all cases.

Successes

The Concerns Team have maintained good working relationships with Clinical Boards and through this partnership have consistently met Key Performance Indicators. We encourage Clinical Boards to share any recommendations for improvement as well as positive feedback.

Feedback from Clinical Boards:

You're great!

The additional support to sign off the final responses was invaluable at such a challenging time.

Nothing is too much trouble and great at keeping us on track

The Surgery Clinic Board appreciate the valuable support that the Concerns and the patient experience team gave to the Clinical Board through the extraordinary period of time in which the Covid pandemic was taking up all the operational time of our clinical and admin teams .
To know that concerns and patient experience team were in contact with families and patients was reassuring and was appreciated by all. It allowed the Clinical Board staff to concentrate on the day to day care of our most vulnerable patients and minimised our workload.

On a personal note with taking this interim role as DoN for SPs over the last 4 months you have been fantastic and I am very grateful for all of the support/ guidance that you have given me.

One point that we discussed if for us to receive the final signed off response this did not happen but I know if I needed to access it would only be a phone/ email request

We have continued to work closely with the concerns team over the past year and the team have successfully supported us with our tracker meetings, responses and management of concerns within the Clinical Board. Over the past year the team have also supported us with some training to update staff and support new staff that had commenced work within the UHB. This was received positively and it was felt more of this training should be delivered.

During the Covid period the concerns team provided MCB with excellent support enabling the clinical teams to remain operationally focused. This was much appreciated by all staff.

As the Lead for concerns within MCB I much appreciate the support and advice that is given from the team and feel that we have good professional working relationships which enables us to continue managing the concerns process effectively.

The concerns team have been a great support to the CB during Covid 19, they managed the concerns process linking in with clinical teams only when absolutely necessary, which allowed us to focus on the frontline response. As a senior nursing team we felt reassured that the concerns team were answering calls to carers and relatives who couldn't visit their loved ones, this level of support was so important and appreciated

I am really pleased with the service provided and have nothing negative to say or suggestions for improvement

Sometimes the claims come in in bulk e.g. I just had 3 in the space of half an hour and I am now advising the Claims manager to also link in with the directorates as well as the clinicians who sometimes don't always understand the processes of waiting lists and RTT etc.

It is difficult to find learning 15- 20 years down the line with some claims, especially in cases where we have settled without any blame
I am not keen on the new LFE forms (more of a personal view)

I would like to think that the partnership working between the Clinical Board and the concerns team works well and I think this is due to the leadership of both the concerns/ claims team and the whole patient experience team.

The whole team have adapted there way of working over the last few months remarkably well. Despite not being in the office full time they were contactable throughout, they adapted there level of support in order to support as much as possible.

What is it like to work in the Concerns Team?

I joined the Concerns team in November 2019 in what was a totally new environment for me after previously being employed at BT for too many years to mention. I am guessing like all new roles there is a time of learning and development when I feel depending on the role you are in you are not sure what you should be doing, who with and when! If you are lucky like I was, your team step forward and advise, guide, support and hold your hand until things become a little clearer.

Then comes the fateful day when you are let loose on your own and take responsibility for your own Clinical Board concerns, where you discover that there are many other people in a kingdom called 'directorates 'just the same as the team in concerns who are striving for the same things that you are. Whether it involves Care, Treatment , Medication, Injury ,Communication, Parking fines , Smoking, Litter, Menus, the list is endless and I was surprised to see how much we were involved in and how we 'Put Things Right'. It's a challenge which I am enjoying and I would readily admit that at times I might share a small amount of frustration, however I think, that could be me or one of my family on the end of the phone or writing that letter.

I get real job satisfaction from the work I do. In my role I deal with concerns on a daily basis and also speak with patients, carers and relatives to discuss and help resolve their concerns.

A typical day is spent dealing with concern which come in via the mailbox, email, letter of concerns form. Some enquiries can be dealt with immediately and others require a formal investigation. Often the calls can be challenging and extremely emotional when patients, carers or relatives are upset, angry or grieving.

The Concerns Team undertake frequent meetings on a weekly basis with the Head of Concerns where we can share cases, ideas and initiatives, which is beneficial and supportive and we are encouraged to explore different ways of working and developing.

Over the years that I have worked within the Team there have been many changes and improvements. We have introduced a Concerns Form, which has proved really helpful for patients, carers and relatives to clearly outline their concerns. We have also introduced a Draft Response template which clearly includes all the questions that need to be answered, and has been well received by the Investigating Officers. I feel that department is continually evolving and adapting to new ways of working to support Clinical Boards and Service Users.

Over the years I have developed excellent working relationships with the Directors of Nursing, Lead Nurses and Services management teams within the Clinical Board, they have been very supportive in helping to resolve concerns through early resolution, but also undertaking the investigations into the formal concerns.

The most rewarding part of the job is when you can resolve a concern quickly, with the help of the Directorates, which is most beneficial for the patient, carer or relative.

Key Achievements

Reduction in referrals to the ombudsman

Introduced a Redress Clinic and invited Directors of Nursing and Investigating Officers to bring cases for discussion or obtain advice on Breach of Duty

Successfully completed a review of all cases following the Welsh Risk Pool (WRP) decision to change their reimbursement process for Claims and Redress

Consistently exceeding the Health Boards target of 80% of complainants receiving a response within 30 working days.

The Concerns/Redress/Claims Team have undertaken various training sessions covering PTR and Breach of Duty throughout the year, including:

- Training to newly qualified Nurses
- All Wales Emergency Unit Consultants
- Directorate Managers, Lead/Senior Nurses and Investigating Officers
- We are currently working with Legal and Risk Services to deliver a training package and had dates secured for this year, however, due to COVID 19, these had to be postponed. Therefore we are looking at ways to provide virtual training and considering developing an online training package.
- Recently introduced a Redress Clinic and invited Directors of Nursing and Investigating Officers to bring cases for discussion or obtain advice on Breach of Duty

The Claims Managers were fortunate to secure an audience with a London barrister to provide a talk on Montgomery law related to Consent. Unfortunately due to the outbreak Covid 19, this booked session has had to be postponed but their aim is to rearrange this event at the earliest opportunity during 2020.

Aims for 2020/21

The Concerns Team has had to adapt to new ways of working during the COVID 19 Pandemic and our aim is to ensure these changes do not impact on the way we manage concerns and support the Clinical Boards.

To ensure that regular tracker meetings are maintained virtually to ensure focus is maintained on providing timely responses.

Develop training sessions for staff that can be delivered virtually or accessed online.

During 2019/20 two reports were issued which Cardiff and Vale UHB has considered.

- The Parliamentary and Health Service Ombudsman (PHSO) – Making Complaints Count report
- The Healthwatch England 'Shifting the mindset – A closer look at hospital complaints' report

Both reports offer direct feedback about what it is like to use the NHS in England and other public services. Complaints matter because feedback can help staff learn from when things go wrong and improve services as a result. However, the complaints system needs reform if people who rely on public services are to have confidence that their voices are being heard and being used to make improvements.

3. Both reports cover a large number of matters and the issues highlighted from across the NHS in England is stark, but remarkably consistent between the reports.
4. The reports indicate a lack of consistency and learning from complaints handling and call for a Complaints Standards Authority and the development of a complaints standards framework. They also show that the NHS needs to invest in its staff through access to better, more consistent, training and professional development in complaints handling. The promotion of a learning and improvement culture from the top is vital.

The Parliamentary and Health Service Ombudsman (PHSO) – Making Complaints Count: Supporting Complaints in the NHS and UK Government Departments report was published on 15 July 2020. The PHSO conducted a thematic review of final investigation reports in NHS England where complaint handling was an issue. Two online surveys of healthcare staff were conducted between October and December 2019 and interviews held with senior staff and complaint handlers. The report focuses specifically on the NHS England complaints system and found:

A lack of consistency on how to deliver excellent complaints handling

- Staff responsible for resolving complaints should be properly trained and ensure that all parties – including staff who are cited in the complaint – are kept involved and engaged throughout.
- A lack of consistency in guidance and approach can have a negative impact on the experience of those who raise complaints.

Developing a Complaint Standards Framework

- PHSO formed a working group to co-design a Complaint Standards Framework. This consisted of UK health and social care regulators, other national bodies, and advocacy groups for people using health and social care services.
- A public consultation on the Framework has been undertaken and a final version is expected to publish in early 2021, The final Framework will be piloted with NHS England for 12 months and will be embedded in the PHSO's own work.

Strengthening oversight on complaints handling and learning from complaints

- There is currently no single organisation that has overall responsibility for developing complaints standards in England and overseeing how these are embedded. Instead, such responsibility is spread across a wide circle of organisations, and this can cause overlap and confusion in ensuring consistency in best practice in complaints handling.

Promoting a learning and improvement culture

- A learning and improvement culture is vital for addressing and learning from feedback and complaints. An effective system – led from the top – demonstrates its commitment to promoting a learning culture that values complaints and feedback.

The Healthwatch England 'Shifting the mindset – A closer look at hospital complaints' report was published on 15 January 2020. It looked at how well NHS hospital trusts across England communicate their work on complaints and found:

Local reporting on complaints is inconsistent and inaccessible

- All hospital trusts report on the numbers of complaint received but only a minority report any more meaningful data
- Just 1 in 8 hospital trusts (12%) demonstrate they are compliant with statutory regulations on complaints

Staff are not empowered to communicate with the public on complaints

- All hospitals must produce an annual statutory complaints report but are only required to make it available upon request. Hospital complaints staff were often not aware of the reports or who could access them.

Reporting focuses on counting complaints, not demonstrating learning

- Only 38% of trusts make public any information on the changes they've made in response to complaints
- Much of the reporting is only high-level and provides little detail about what had changed only stating 'improvements were made'

Complaints Standards Authority

- A recommendation is made in the report for a single organisation to act as Complaints Standards Authority in England to develop national good practice, training and monitoring reporting and learning from complaints

Having reviewed both reports, it is considered that the "Putting Things Right" regulations in Wales encompass the recommendations.