DYDDIAD Y CYFARFOD: 28 May 2020
DATE OF MEETING: 28 May 2020

TEITL YR ADRODDIAD: Improving Patient Experience
TITLE OF REPORT: Improving Patient Experience

CYFARWYDDWR ARWEINIOL: Mandy Rayani, Director of Nursing, Quality & Patient Experience
LEAD DIRECTOR: Mandy Rayani, Director of Nursing, Quality & Patient Experience

SWYDDOG ADRODD: Louise O’Connor, Assistant Director (Legal Services / Patient Experience)
REPORTING OFFICER: Louise O’Connor, Assistant Director (Legal Services / Patient Experience)

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)
Er Sicrywydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation
The attached report provides a summary of patient experience feedback and activity for the period 1st January to 30th April 2020.

Cefndir / Background
The University Health Board (UHB) is highly committed to improving the patient experience and welcomes feedback to continually improve outcomes and experiences for our patients.

The Board is asked to note the adaptions and new ways in which the PALS team is supporting service user and family experiences, due to the Coronavirus Pandemic (COVID 19).

Asesiad / Assessment
The attached report shares a patient story from Ingrid, who has had a very positive outcome from participating in the escape, pain management and physiotherapy programme, based in Ceredigion. Ingrid’s mobility and quality of life has improved significantly.

Patient and service user feedback is received into the UHB through a variety of routes: Friend and Family Test; compliments (formal letters and the Big Thank You); formal concerns, informal concerns; Patient Advice and Liaison Service (PALS) feedback; local surveys; focus groups, on line feedback through the Friends and Family Test (FFT); the all Wales NHS survey and via social media.

Due to recent events associated with the pandemic, the ways in which feedback is captured have been reduced. A plan is in place to re-start the capture of experience. The volume of feedback received is significantly less than the previous period, due to the reduced patient activity across our hospitals. From the responses received, the satisfaction levels have increased to 92% of participants who would recommend the service and ways in which the service can be improved are being reviewed to further increase this score. Examples of voice and text responses are included within the report.
The main areas of activity for the Patient Experience Team are also summarised, which highlights the positive work undertaken to improve experiences and promote a positive culture for encouraging and sharing feedback, including specific arrangements for supporting patients and families during times of restricted visiting. These include new schemes such as the Thinking of You service and the patient property delivery and collection service. A new family liaison ward role is also due to be implemented during May/early June 2020, which will be a protected role to support communication and patient experience.

For the period of January to April 2020, a total of 1905 contacts were received into the patient support contact centre, many seeking advice and support, 620 were complaints managed through the putting things right process.

The annual complaints figures presented to Welsh Government are provided in the report. For the period March 2019 to April 2020, 3229 complaints were received and recorded, **73% of concerns were responded to within 30 working days**; however the Team is working hard to continually improve on the timeliness of concern responses and achieving a quality response.

Areas for improvement continue to be associated with appointments and waiting times and delays in diagnosis, receiving test results and communication.

**Public Services Ombudsman** – Between March 2019 and 30th April 2020, **24 cases had proceeded to formal investigation**. No concerns are raised in relation to compliance with timescales and agreed actions at this time; however the report does indicate one action which has exceeded the agreed date for action. The Health Board is in contact with the Ombudsman’s office regarding this.

To continue to support the learning culture in the organisation, a variety of learning and improvement initiatives continue to be undertaken, these are as follows:

- Patient Safety Awareness Day
- Quality & Safety Newsletters
- Establishment of patient forums
- Learning from Events Flyers
- Case Study presentations
- Improvement workshops
- Patient Participation Groups

**Argymhelliad / Recommendation**

The Board is asked to receive the report, which highlights to patients and the public the main themes arising from patient feedback, together with examples of action being taken in response to findings from investigations.

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<th>Objective: (must be completed)</th>
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<td>Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:</td>
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<td>Datix Risk Register Reference and Score:</td>
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<td>6. (ref 581) Health Board wide risk not learning from events in a timely manner (current score 8).</td>
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### Further Information:

**Evidence Base:**
NHS (Concerns, Complaints and Redress Arrangements) (Wales) 2011

**Glossary of Terms:**
Included in body of report

**Parties / Committees consulted prior to University Health Board:**
Not applicable

### Impact: (must be completed)

**Financial / Service:**
All concerns have a potential financial implication: whether this is by way of financial redress, following an admission of qualifying liability, or an ex-gratia payment for poor management of a process; or an award made by the Ombudsman following his review of a concern.

**Quality / Patient Care:**
Information from concerns raised highlights a number of clinical and service risks which should be reflected in directorate and corporate risk registers. There are financial and reputational risks associated with complaints that are upheld or not managed in accordance with the Regulations. The UHB also has a duty to consider redress as part of the management of concerns, which carries financial risks associated with obtaining expert reports and redress packages.
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<th>Gweithlu:</th>
<th>Improving the patient experience and outcomes for patients is a key priority for the UHB. All concerns received from patients, public and staff alike are taken seriously and investigated in accordance with the procedures. Information from concerns raised, highlights a number of clinical and service risks which should be reflected in directorate risk registers. All directorates are required to have in place arrangements for ensuring lessons are learnt as a result of investigation findings on concerns and that appropriate action is taken to improve patient care.</th>
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<td>Workforce:</td>
<td>The putting things right process is designed to support staff involved in concerns and incidents. All managerial staff have a responsibility to ensure staff are appropriately supported and receive appropriate advice throughout the process. The success of the process is dependent upon the commitment and support from staff across the organisation, not only as part of the investigation process and being open arrangements, but in the encouragement of patients and their families to provide feedback, both positive and negative, to support organisational learning.</td>
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<td>Risg:</td>
<td>The UHB has a duty under the Concerns and Redress Regulations to consider redress where this is deemed to be a qualifying liability. The Regulations also incorporate formal claims, including clinical negligence and personal injury claims.</td>
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<td>Risk:</td>
<td>There are ongoing reputational risks for the UHB in relation to media, press and social media regarding any concerns, and outcomes from published Ombudsman Reports and any external investigations/inquiries.</td>
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<td>Cyfreithiol:</td>
<td>Only relevant information is reviewed as part of the concerns process and this is carried out with the explicit consent of the patient or authorised representative. Information is recorded and treated sensitively and only shared with people relevant to the investigation process.</td>
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<td>Legal:</td>
<td>The process is established to learn from concerns: it is designed to ensure that it is fully accessible to patients and their families. The aim is to involve patients throughout the process and to offer meetings with relevant clinicians, with the required support depending upon individual needs. Advocacy is offered in the form of CHC advocates, and specialist advocacy is also arranged where necessary, e.g. in the areas of mental health, learning disability or children/young people’s services. Concerns literature is accessible in a range of languages and formats and translation services are available, when required.</td>
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