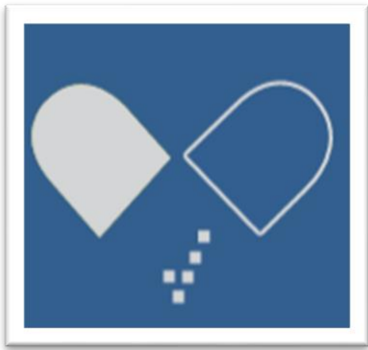
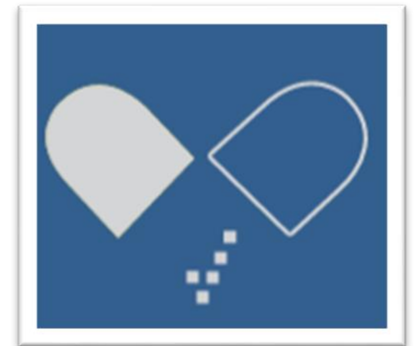
Velindre University NHS Trust
2023/2024 Putting Things Right Annual Report





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Introduction

Velindre University NHS Trust is a provider of specialist cancer, blood, and transplantation services, bringing together expert staff, high quality cancer care, donor, and transplantation services, excellence in research, development, and innovation. We have built a strong reputation across the United Kingdom and internationally for the services we provide.

The Trust have two main divisions: Velindre Cancer Service (which provides specialist tertiary non-surgical cancer care) and the Welsh Blood Service (which is responsible for the provision of blood and blood products) to NHS Wales.

The effects of harm, when something goes wrong, can be widespread and have devastating emotional and physical consequences, not only for the service users, but also for family members or representatives acting on their behalf.

The Trust places a high value on ensuring that we keep patients and donors at the heart of everything we do, and are grateful for the continued level of assistance, encouragement, and feedback that we get from our patients, donors, staff, and partners.

Whilst we pride ourselves in delivering high quality and safe services, there are occasions when things go wrong. When this happens, we are committed to resolving these matters with transparency and in accordance with legislative and national requirements in particular the NHS (Concerns, Complaints and Redress Arrangements) (Wales) 2011 commonly known as Putting Things Right (PTR).

Velindre University NHS Trust 2023-2024 Putting Things Right Annual Report provides an overview of how the Trust has managed concerns during the period of the 1st of April 2023 to the 31st of March 2024. The report outlines how our systems and processes have developed for the effective investigation and engagement with patients, donors, and their families, providing comprehensive responses. This ensures that changes have been made, lessons have been learned and action outcomes disseminated following the investigations.

The Putting Things Right Regulations refer to the term “concern” which means any complaint, claim, or reported patient safety incident (about NHS treatment or services). This report sets out the themes in complaints, incidents, and redress cases. In this year’s annual report, we have extracted learning from concerns and redress cases into themes in a section of the

report focused on learning. As an organisation we are committed to learning from concerns to ensure we prevent avoidable harm and improve patient and donor experience.

Executive Summary

2023-24 At a Glance

Number of Concerns Raised	Number managed as Early Resolution	Number managed under Putting Things Right (PTR)	Compliance with PTR timescales
202	147 (73%)	55 (27%)	93%

Did we do what we said we would during 2023/24

In last year's annual report, we set our priorities for 2023-24. How did we do?

- We said we would **continue to listen to our patients, their carers, and our donors, putting things right where things have gone wrong**. The Trust has continued to adhere to the Putting Things Right regulations, reporting and recording concerns, and acting on feedback received, learning from what we find, and putting in place actions to improve.

- We said we would **fully implement and embed the new requirements of the Health and Care Quality Standards**. The Trust has adopted the Standards in full, including the new Duty of Candour. We have put quality at the heart of our processes and decision making and built robust quality governance structure to ensure this continues.

- We said we would **establish a Quality Management System.** The Trust has developed two new frameworks: the Incident Management Framework and the Learning Framework. The frameworks set out how we manage, respond to, and learn from concerns.

- We said we would establish **“Always on” reporting metrics** to aid continual improvement opportunities and real time investigation of concerns that are raised. We have started Always on reporting of patient experience measures, however we need to expand this much further during 2024-25.

- We said we would **implement a revised Complaints, Incident and Claims Policy** in line with current legislation and Welsh Risk Pool protocols. These have been updated and approved.

- We said we would **devise and implement standard operating protocols which will incorporate Learning from Events flowcharts, PTR Panel and Redress flowcharts**. Following appointment to key Quality & Safety positions in the Trust, significant work has been undertaken to review and update our protocols in regard to the above.

- We said we would **review and audit the Once for Wales Datix Cymru system** for all our concerns modules. Regular audits are now taking place and are showing that review arrangements are in place to provide assurance that any errors identified will be rectified.

- We said we would **continue professional development**. As well as undertaking additional complaints and serious incident investigation training, the Quality & Safety teams have engaged staff across both divisions to provide update training and support, as well as feeding back learning after incidents and concerns.

- We said we would **enhance the recording of compliments on the Datix system**. Velindre Cancer Service has taken this action forward and is now utilising a range of methods, including the Datix system, to record and share compliments received for the service.

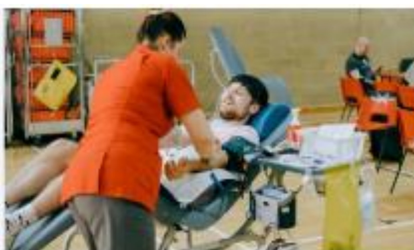
We also recognised the importance that positive feedback can have on staff wellbeing and developed in collaboration with our Communications Team a **‘Wall of Thanks’** to share patient and donors’ kind feedback.

"To all at radiotherapy, thank you for your kindness and support."

"The staff in our café always make such an effort! They are all fab!"

"To all the staff at Reception, LA4 and LA2, thank you so very much for your care and kindness not only to me but the other patients that visit Velindre. You are amazing."

"For the past many weeks I have been a patient at Velindre, under the care of Oncologist Dr Louise Harris. This is a note to express my sincere gratitude for the care generally, which has been beyond measure in its excellence.



Platelets

"The biggest joy of the platelet donation process is that the team know me (and the other donors) which makes for a very relaxed and welcoming environment. Thank you."

East A

"I was unable to donate blood again due to having poor veins.Staff were amazing and supportive towards me, made me feel at ease as I also have a phobia with needles. Staff sat with me afterwards as I was gutted I couldn't donate. I will definitely keep trying."

East B

"Fantastic staff as always,

Bangor

"Diolch i'r holl staff am fod mor glên. Hefyd mor braf cael staff Cymraeg i helpu."

West

"I always enjoy my blood donation sessions, I actually look forward to seeing the lovely team of staff and feeling I have done something worthwhile. Thank you, you are a fantastic team."

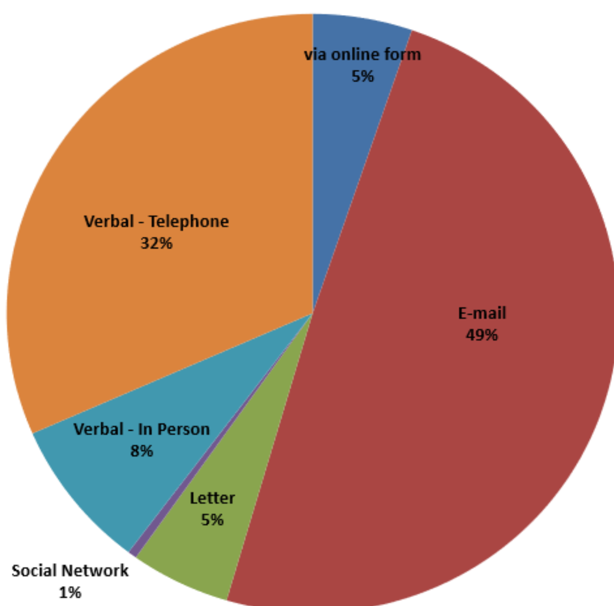
Complaints Management

Raising a concern will be easy and information will be widely accessible. Put the complainant at the centre of the process and provide support for individual requirements.
Listen to concerns and treat everyone with dignity and respect.

Complaints are received via several routes and is evident that e-mail communication remains the preferred method of contacting the Trust, with **49%** of complaints being received in this way. The Trust has seen a 6% reduction in complainants using email to raise concerns, in comparison to the previous year. Velindre Cancer Service have introduced a new online form for complaints, which accounts for the reduction in email contact.

Feedback reporting channels include:

ONLINE | TABLET | EMAIL | PHONE | QR CODES

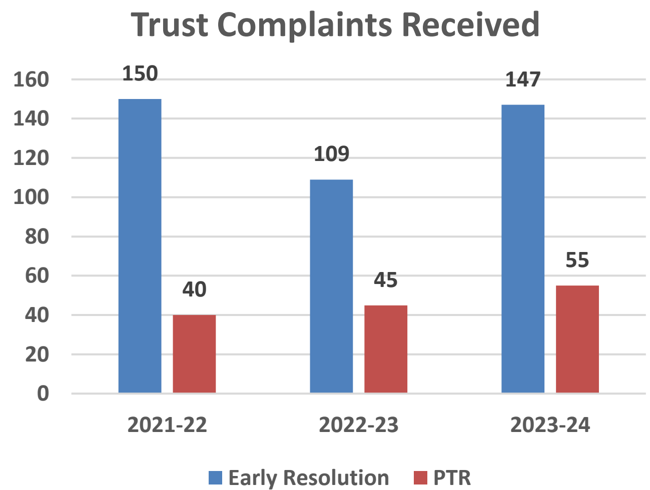


The Trust has positively engaged with Llais by meeting with their Public Engagement Officer and requesting feedback from members of the public on how they would like to see our information presented. We include Llais information and leaflets in all our complaints correspondence to signpost patients, donors, and families to the advocacy services they provide for people who want to raise a concern.

Complaints Received

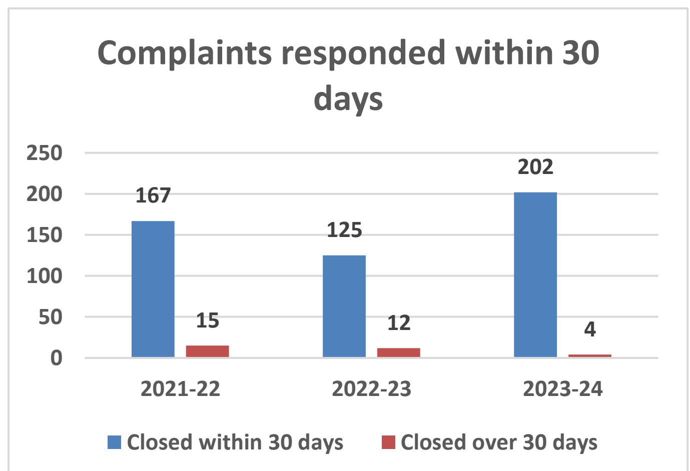
Acknowledge all concerns within 2 working days.
Aim to resolve concerns at source, or by the end of the next working day. Responses required under PTR will be provided within the legislative timescales.

202 complaints were raised, equating to less than **0.06%** of patient and donor contacts. The number of complaints has risen in comparison to previous years (see graph on right), however as a percentage of activity this remains unchanged. When a complaint is investigated under Putting Things Right, an acknowledgment is provided to the complainant within 2 working days of being raised. Welsh Government requires Health Bodies in Wales to thoroughly investigate all complaints received and that 75% of these be resolved within 30 working days of receipt.



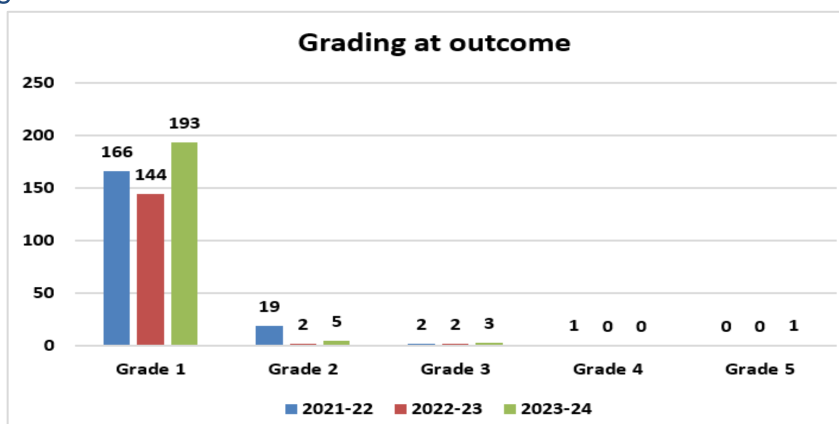
How did we do?

Due to Datix system changes the Trust only has direct comparative data over the last three years. The Trust has continued to respond comprehensively to all complaints during 2023-24, with 93% being investigated, resolved, and closed within 30 working days of receipt (Welsh Government target is at least 75%) and 73% of those received were successfully resolved via the 'early resolution' process.



Complaint Grading

All complaints are graded upon receipt, from 1 (No Harm) to 5 (Catastrophic Harm) in accordance with the All-Wales Grading Framework. This will determine the level of investigation required in dealing with the issue(s) raised. All complaints undergo an assessment of harm to determine the grading and whether there is a possibility that the Trust may have breached its duty of care, to ensure that the appropriate level of investigation is commissioned.



98% of the complaints raised were low level with no or low harm and graded a level 1 or 2, this is an increase of 3% on the previous year.

There were three grade 3 and one grade 5 complaints. These related to issues including:

- Communication throughout treatment
- A delay in chemotherapy
- Pain management
- Staff conduct
- Chemotherapy dosage and discharge planning

Within Velindre Cancer Service, identified concern and learning themes during this period relate to **appointments**, **patient communication** and **treatment planning,** with several specific trends being evident and are highlighted below**:**

- The theme around communication and appointments, highlighted in previous reports, continues. Patients report difficulty contacting departments particularly medical secretaries (phones not being answered and voicemails are not returned). In relation to appointments – patients continue to report lack of communication around SACT and outpatient appointment date, location, and time changing without appropriate communication. A meeting was held with the Director of Cancer Services and Head of

Medical Records in quarter 4 to discuss the issues and an improvement plan has been put in place.

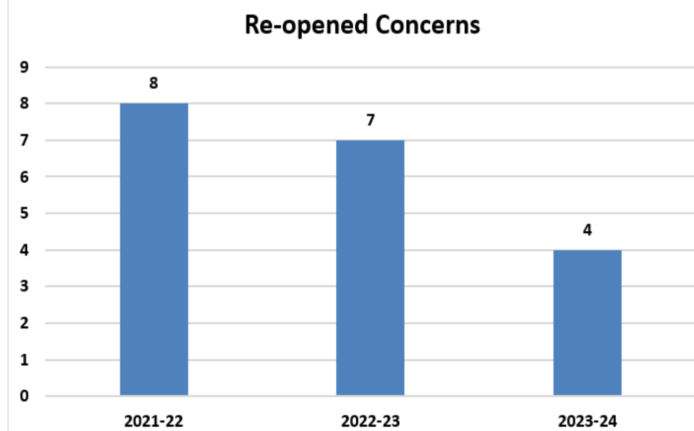
- A recurrent theme around the length of time patients are waiting resulted in the lowest patient satisfaction score to waiting in outpatients dept and radiotherapy. The scoring for "How did you find the waiting time in your recent visit" has been reviewed and adjusted as it was negatively scoring the "about right" response. This has now been made a positive score which has therefore shown an increase in the overall percentage.

Within the Welsh Blood Service, top complaint themes during the reporting period were identified and relate to **appointment & communication** issues which are shared at a divisional level for consideration and to address.

Learning and improvement identified from complaints and incidents can be found on page 19.

Re-opened Complaints

Occasionally a complainant will be dissatisfied with the formal response they have received or require further information and will contact the Trust again. In these instances, the complaint will be re-opened. The number of re-opened complaint can be an indicator of the quality of investigations and responses.



There were **4** complaints re-opened during the year. There has been a steady reduction in re-opened complaints over the last 3 years (see graph right). All 4 of these were promptly reviewed, re-investigated when required and managed, through to final closure.

As part of our complaint response improvement work, we have focused on ensuring the provision of a comprehensive initial response. The 4 cases were re-opened as the complainant raising further queries following the Trust response, seeking clarification on particular elements of the response.

Welsh Language Complaints

The Trust did not receive any complaints relating to the provision of services in the Welsh. There were no complaints in respect of the Welsh Language provision on patient and donor facing internet pages. The Trust Welsh Language Officer continues to update the current internet platform to include content in both the English and Welsh languages. This includes ensuring Welsh versions of Trust policies and procedures are available in line with Welsh Language Standards requirements.

Complaints training and improvement

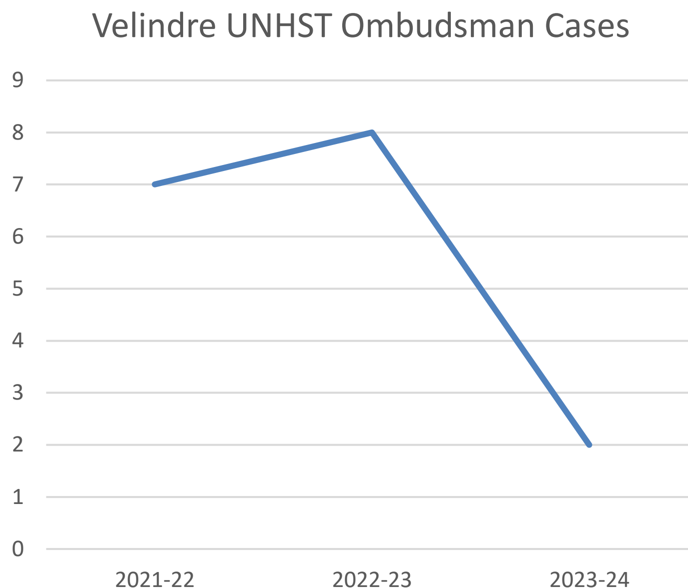
The Trust commissioned training on how to complete effective responses to complaints, that focussed on the principles of good complaint handling and effective writing skills. 13 employees who are involved in the management and investigation of complaints attended this training. Following this training, the complaint template letters were reviewed to ensure they reflect the good practice learned in the session, and that they are accessible for people who require reasonable adjustments.

Public Services Ombudsman for Wales

When a complaint cannot be resolved to the satisfaction of the complainant, they can refer the matter to the Public Service Ombudsman for Wales (PSOW), an independent government body offering free, impartial services to those wishing to raise complaints in relation to public bodies and NHS organisations throughout Wales. The Ombudsman has legal powers to uphold concerns and make recommendations for learning and improvements to prevent similar incidents from happening again. Where an investigation outcome finds that significant injustice has occurred to a complainant, the PSOW can make its findings public. Any public report is shared across NHS Wales.

Despite every effort to provide a comprehensive response to the issues raised, there will, on occasion, be complainants who will remain dissatisfied with a response. To help mitigate against this, the Trust offers the opportunity to meet with relevant personnel to address any unresolved issues in the hope of reaching a resolution to their complaint.

The Trust was referred to the Ombudsman on two occasions. The areas of concern referred to the ombudsman included lack of or poor communication / documentation, delay in referrals / follow up appointments, and delay/failure to treat. These are shown in the graph to the right.



Outcome/Recommendations relating to Velindre University NHS Trust

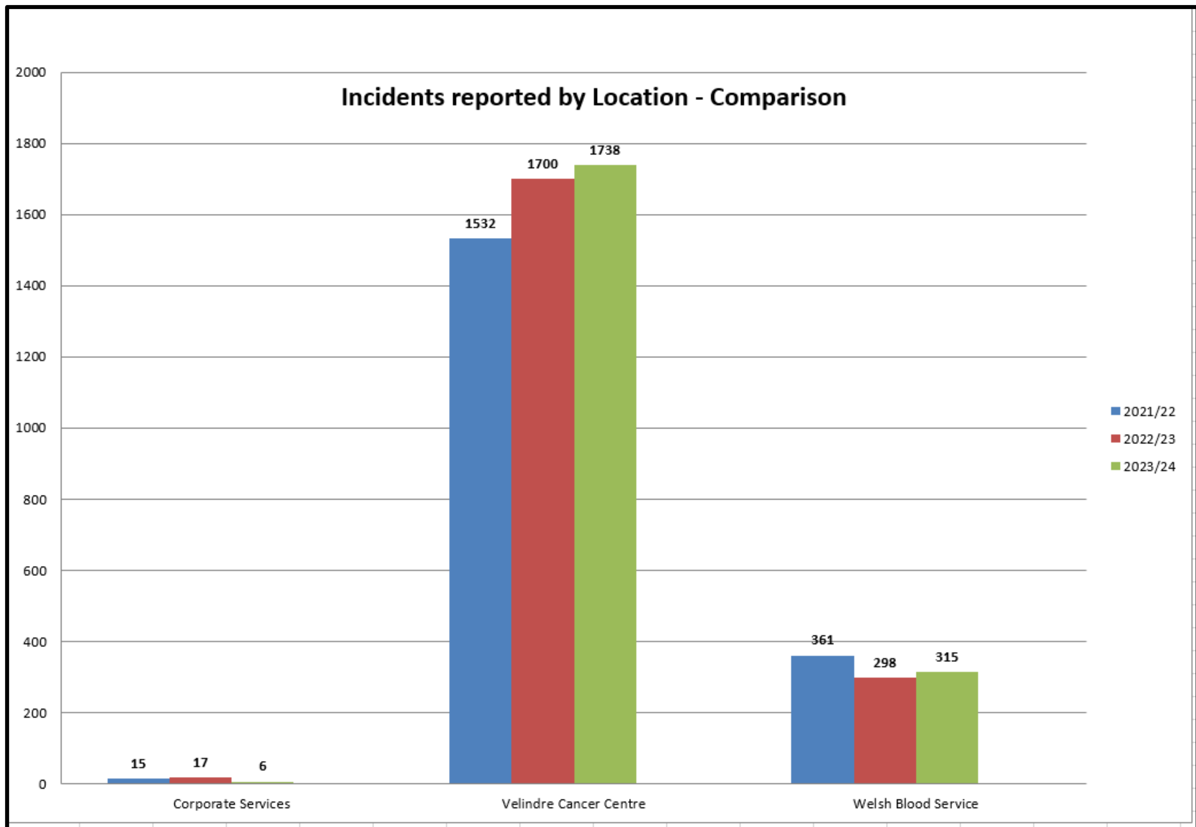
Following an Ombudsman investigation, a final report was issued to the Trust. The Ombudsman felt that the patient should have been offered treatment and that a more balanced explanation involving the risks and benefits should have been discussed and documented. In this regard, the Ombudsman upheld the complaint. Although it was felt that treatment was unlikely to have made a difference, the Ombudsman considered that this had created a level of uncertainty which, in itself, was an injustice for the patient. The Ombudsman made the following recommendations:

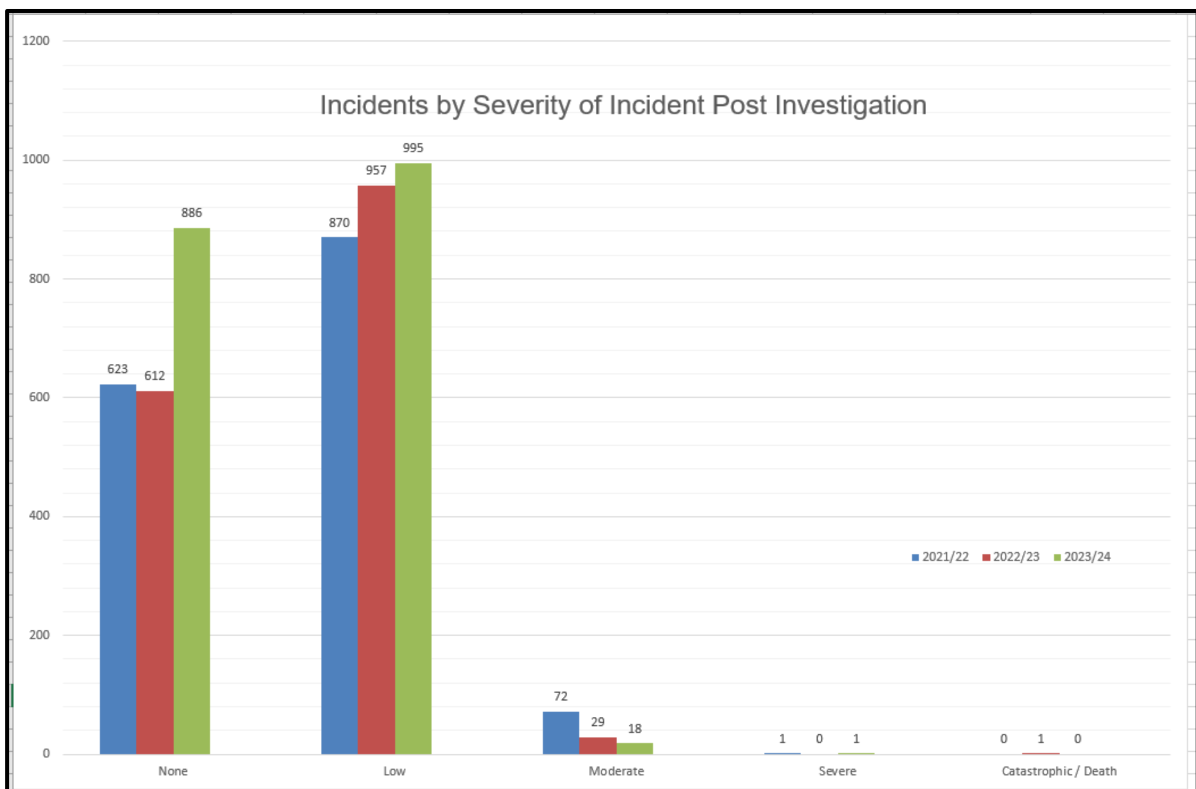
- To apologise for the failings identified in the report and
- To review its documentation and communication relating to the decision taken and for staff to be reminded of relevant national guidelines.

Incidents

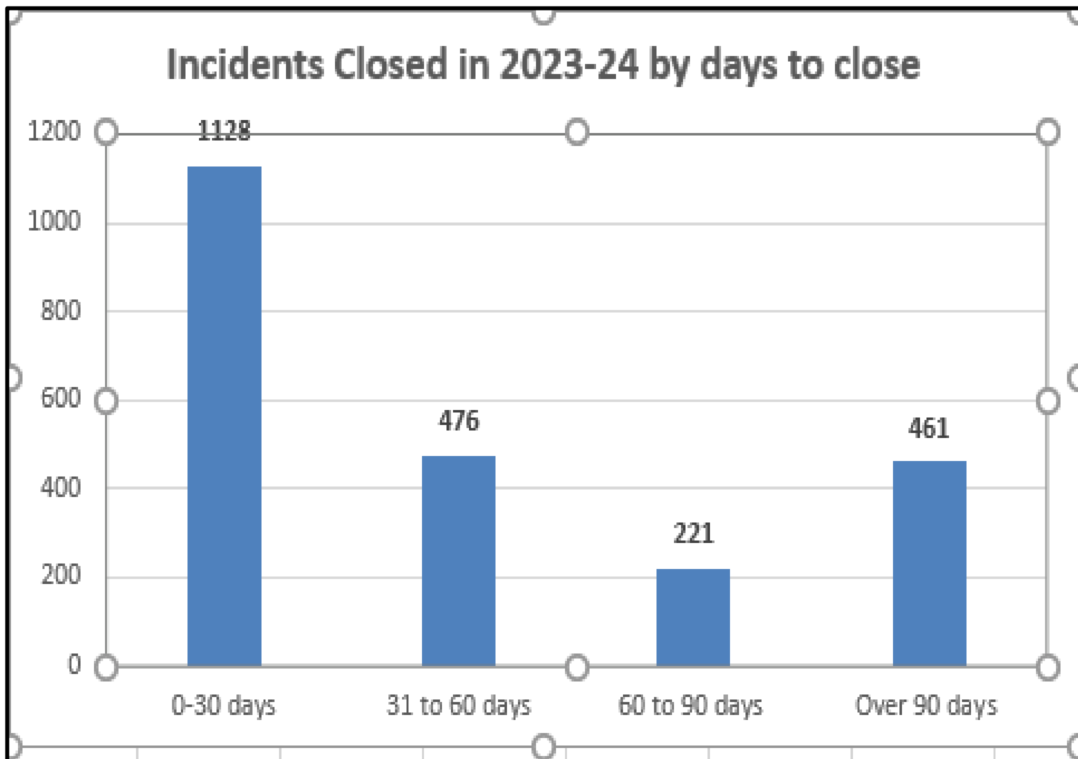
An incident is described as an event or circumstance that resulted in or could have resulted in unintended harm, complaints, loss, or damage to one or more patients/donors or service users. This includes adverse events, near misses and omissions where potential benefits from medical interventions were not provided. The Trust reports all incidents using the DATIX Cymru system.

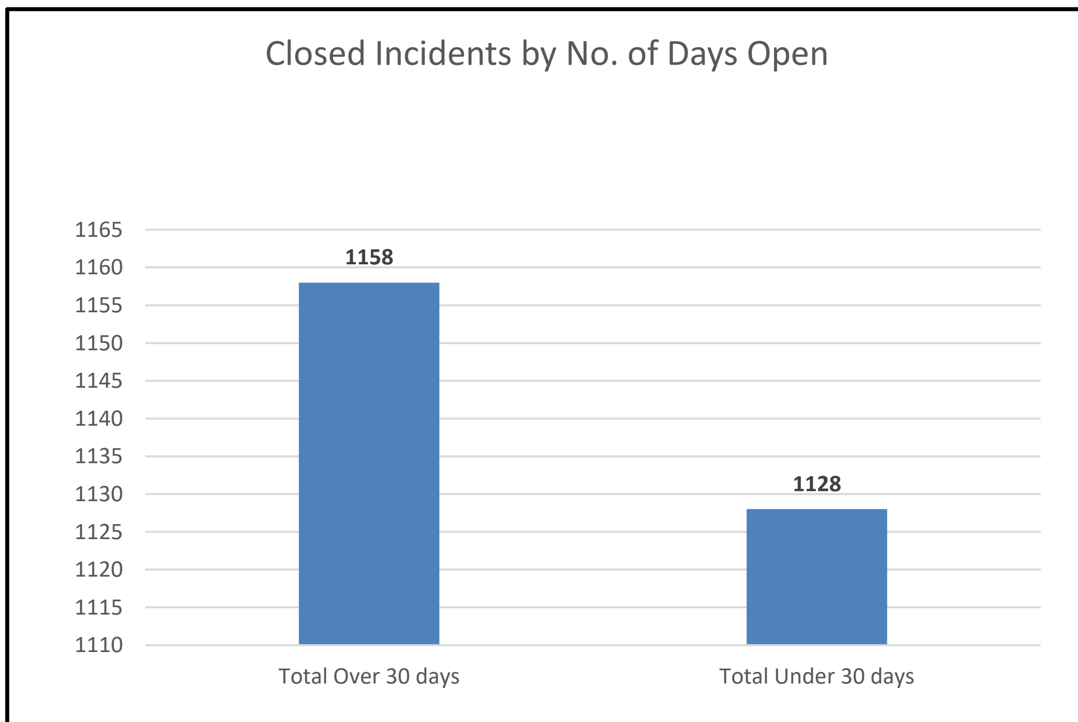
2059 incidents were reported across the Trust throughout 2023/24. The Trust recorded 245,535 patient contacts by Velindre Cancer Service and 89,490 Welsh Blood Service donor attendances, equating to a 0.6% of activity. The graphs below display the number of incidents by each Division and investigated, with the severity confirmed at closure by comparison to previous years.



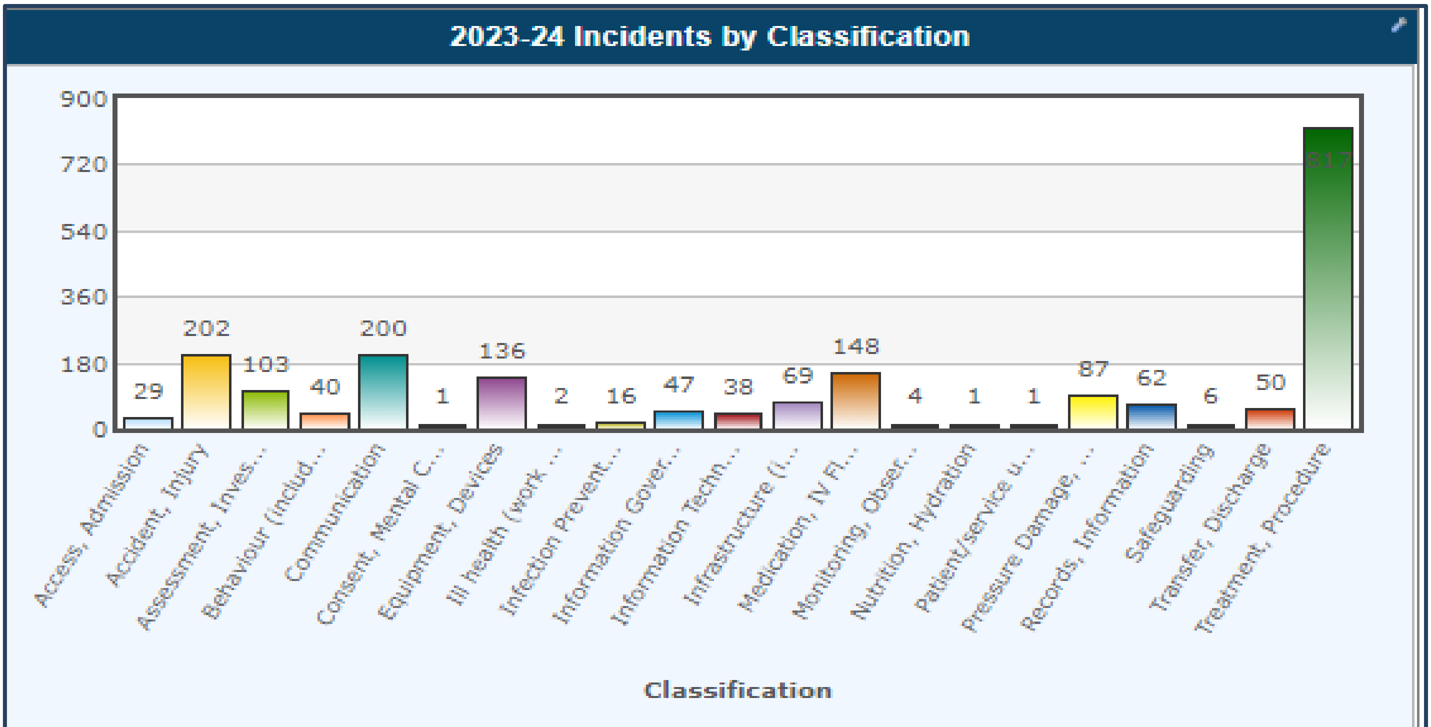


The Trust has improved the time taken for incidents raised via the Datix system to be investigated and concluded. Dashboards have been created within Datix to show all open incidents and for every directorate. These Dashboards have been introduced in the monthly directorate meetings, with focused action taken in service areas where there have been delays. This has resulted in a reduction in incidents open over 30 days from 570 in Quarter 4 2022/23, to 162 in Quarter 4 2023/24.

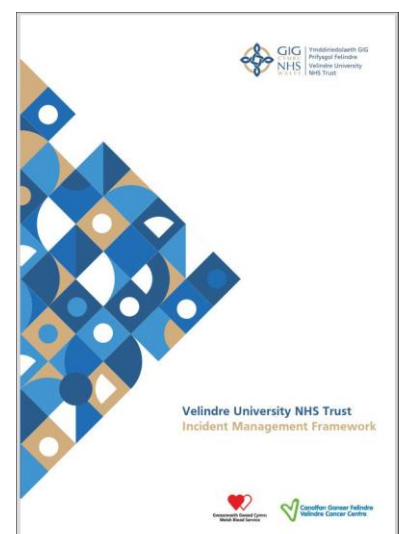




Treatment and Procedure was the highest category of incident reported.



The Trust has revised its Incident Management Framework. The purpose of the Framework is to support colleagues in the management of incidents, guide decision making, establish a standardised approach, and help us learn as an organisation. The emphasis of the Framework is on taking a compassionate approach to incident management. It reinforces proportionate investigations in the spirit of *investigate once, investigate well*. The Framework takes consideration of human factors and psychological safety and promotes SMART action plans. Next steps will include embedding the approach described in the Framework into the culture.



We have also introduced a rapid review /Make It Safe meeting for incidents graded moderate or above, or where there are potential near misses, or themes and trends. This meeting promotes the concept of psychological safety and a ‘no blame’ learning culture. The meeting allows staff to find risk reduction solutions and identify system improvements using a collaborative approach. Following these meetings, a Terms of Reference for an investigation is agreed and any support for individuals involved in safety incidents is considered.

Duty of Candour Triggers

From 1st April 2023, the Duty of Candour became a legal requirement for all NHS bodies in Wales. It requires organisations to be open and transparent with their patients where harm is caused whilst receiving health care. The Duty of Candour is outlined in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and applies if the care we provide has, or may have, contributed to "*unexpected or unintended moderate or severe harm, or death".*

The Trust is required to review incidents to determine whether the procedure has been triggered and follow the Duty of Candour notification processes. An investigation then takes place in line with Putting Things Right Regulations 2011.

The Duty of Candour has led to a closer, more timely, scrutiny of incidents in the Trust. There were 8 incidents that triggered the Duty of Candour. 2 of which remain under investigation.

What do we mean by moderate or severe harm?

Moderate Harm:
A service user experiences a moderate increase in treatment and significant but not permanent harm, and the care provided by the NHS did or may have contributed.

For example, they are given medication despite this being documented in their notes as an allergy, and this leads to a significant reaction requiring four or more days in hospital before recovery.

Severe Harm:
A service user experiences a permanent disability or loss of function and the NHS care did or may have contributed.

For example, they are given medication despite this being documented in their notes as an allergy, and this leads to brain damage or other permanent organ damage.

Death:
A service user dies and the NHS care did or may have contributed to the death.

For example, they are given medication despite this being documented in their notes as an allergy, and this leads to their death.

What can you expect?

Here is a summary of the Duty of Candour Procedure that the NHS will follow:

On first becoming aware that the duty of candour applies, the NHS must notify the service user or a person acting on their behalf. This contact should be 'in person', which means by telephone, video call or face to face.

The purpose of the 'in person' notification is to offer an apology, provide an explanation of what is known at that time, offer support, explain the next steps and provide point of contact details.

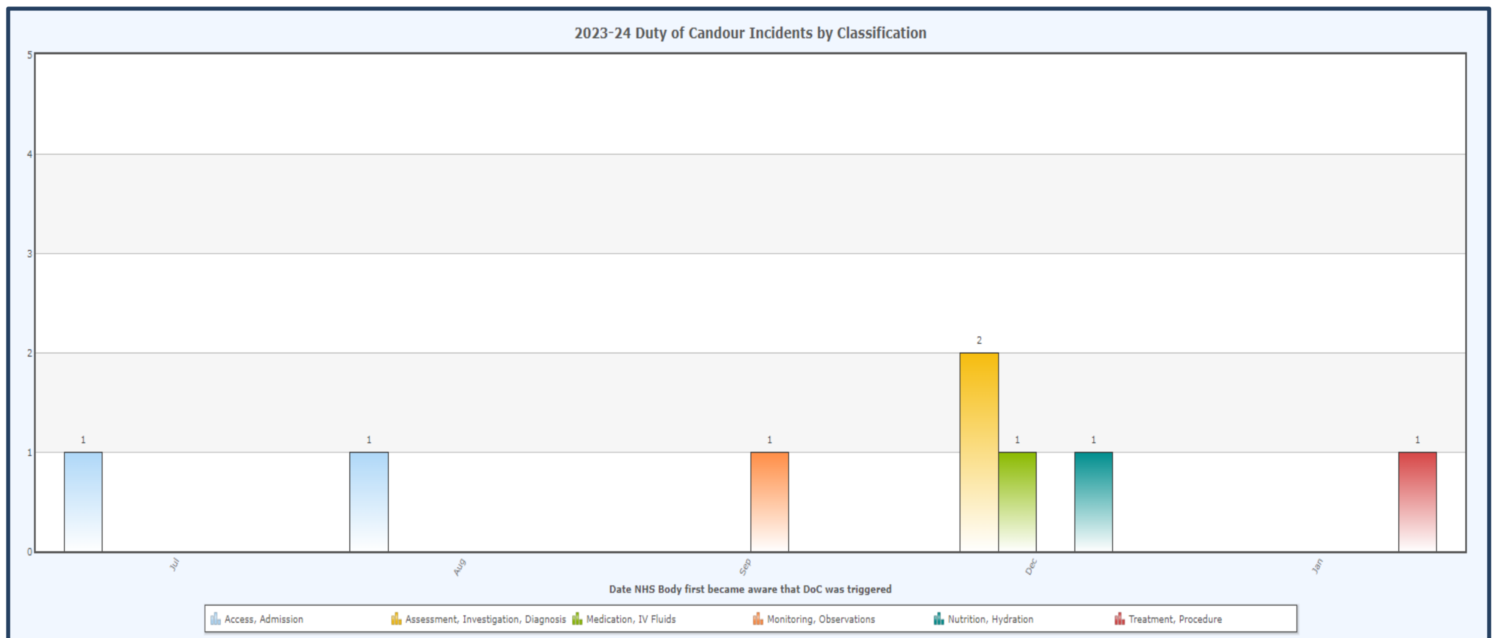
The service user or person acting on their behalf will be sent a letter within five working days, confirming what was said in the 'in person' notification.

The NHS will undertake an investigation to find out what happened and why, and how we can prevent it from happening again.

This will take place according to the NHS Wales 'Putting Things Right' Procedure.

The named point of contact provided as part of the Duty of Candour procedure will give you more information about this process and what happens next.

The table below refers to the incidents that have triggered the act since its inception in April 2023:

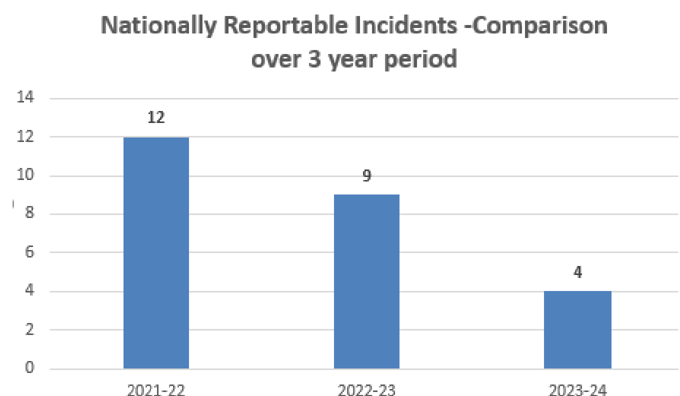


Duty of Candour incidents included delays to treatment, and a theme emerged relating to referral processes at Velindre Cancer Service. These include internal referral management processes, as well as referrals made to other organisations for follow up care. Learning and action taken is described on page 19.

National Reportable Incidents (NRIs)

Any patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff, or members of the public, during NHS funded healthcare, is nationally reportable. The Trust report all National Reportable Incidents to the NHS Executive.

There were **4** incidents that met the threshold to be reported nationally. A continued steady reduction of NRIs has been seen over the last three years as previous shown in the chart. However, the criteria for NRI changed in 2021, requiring a higher threshold.



The main theme relating to NRIs is lack of robust referral processes at Velindre Cancer Service. Some of the identified issues included:

SUMMARY OF CARE SERVICE DELIVERY ISSUES IDENTIFIED

Issue 1	Velindre Cancer Service lacked a robust referral management system, relying heavily on email and letter correspondence via number of routes (inboxes and recipients). Variation in practice was identified.
Issue 2	Evidence of lack of adherence to policy and procedures.
Issue 3	A lack of support and training for Junior medical staff on the importance of oncology drug prescribing, outpatient follow up, and important actions for the GP during the discharge process.
Issue 4	An overreliance on email as a method of communicating urgent clinical matters within Velindre Cancer Service, leading to delays in treatment
Issue 5	Staff sickness, workload capacity, and supervision.

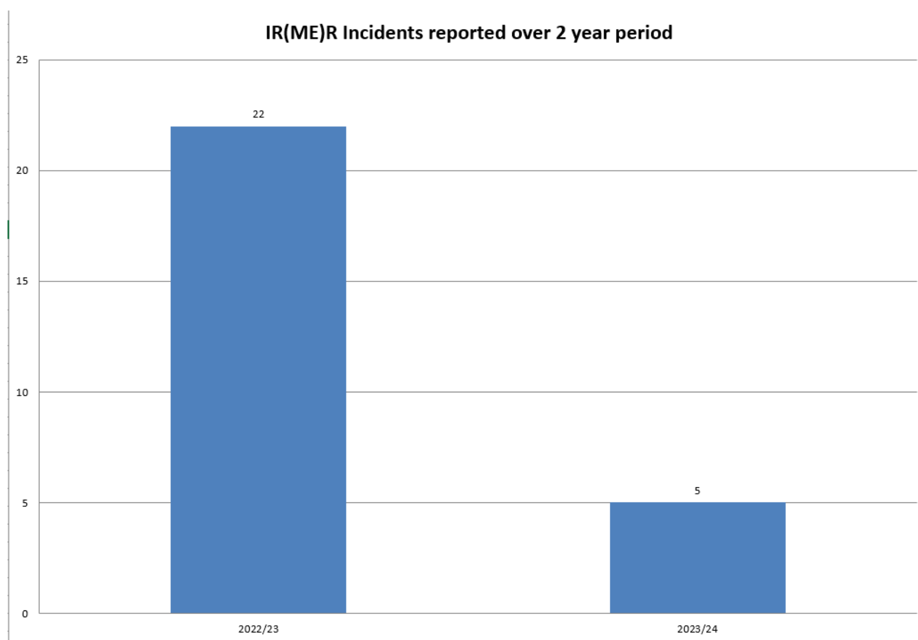
For further details on improvements that have been made, please see the Learning and Improving section on page 19.

A key theme identified last year (2022/23) was avoidable harm attributed to inpatient and outpatient falls. Improvement work has been undertaken to reduce the risk of patient falls at the Cancer Centre, and, as a result, this year there have been no incidents of avoidable harm related to falls. Work undertaken included the development of a new Standard Operating Procedure for the reduction of falls risk, the introduction of a falls scrutiny panel to draw learning where they occur, and the purchase of improved chairs in the outpatient department.

Ionising Radiation (Medical Exposure) Regulation (IR(ME)R) Incidents

When there is an accidental or unintended exposure to ionising radiation, and the **IR**(ME)R employer knows or thinks it is significant or clinically significant, they must investigate the incident and report it to the appropriate UK IR(ME)R enforcing authority (under Regulation 8(4). The Trust reports such incidents to Health Inspectorate Wales (HIW).

The Trust reported **5** Ionising Radiation (Medical Exposure) Regulation (IR(ME)R Incidents to HIW during 2023/24 this shows a marked reduction in the number being reported in the previous year, where 22 IR(ME)R incidents were reported and were mainly attributable to an equipment related issue stemming from a known national manufacturing fault with Elekta Xvi system.

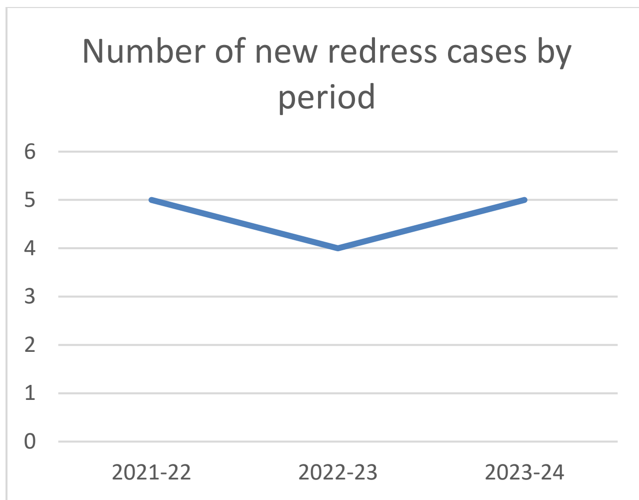


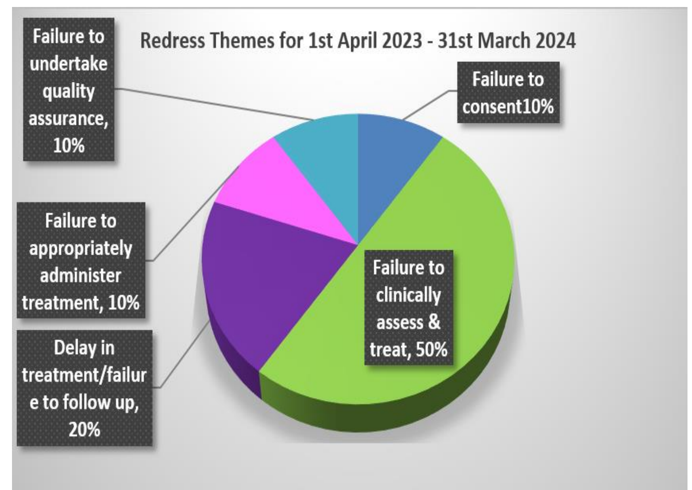
All of the incidents reported in 2023/24 met the criteria for no or low harm but met the reporting classification specifications and were fully investigated with a theme of data recovery errors which have been rectified by Radiotherapy Physics. No concerns were raised by UK Health Security Agency or Health Inspectorate Wales regarding these incidents.

Redress

A case is transferred under the Redress arrangements of the Putting Things Right Regulations (2011), when it is identified that a breach in the duty of care has occurred and a service user has suffered harm, or potential harm, caused by the breach of duty. Where an investigation concludes that a breach of duty and harm has occurred, the case is presented to the Trust's Redress Panel who determine if a qualifying liability exists or may exist.

There have been 5 new redress cases. Please see table below for Redress themes.





The remedies available in relation to the Redress arrangements in accordance with the Putting Things Right Regulations include:

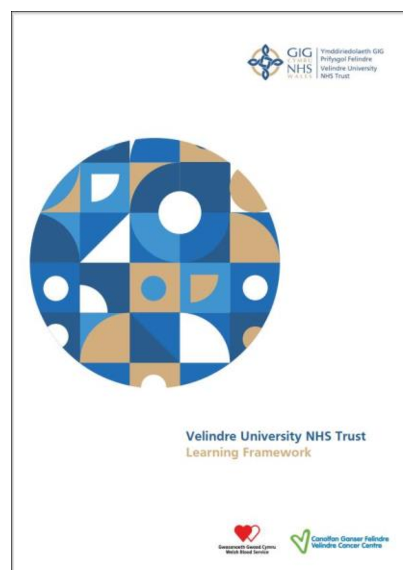
- A full explanation of what happened.
- A written apology
- A report on the action which has been or will be taken to prevent similar cases. arising and/or
- An offer of financial compensation and/or remedial treatment up to £25,000.

There has been an increase in redress matters during this year. This is related to the impact of the legislative Duty of Candour requirements, which came into effect on 1st April 2023 resulting in a notable increase in the number of concerns triggered by the legislative Duty of Candour requirements,

Learning and Improving

Ensuring that we learn and improve when things go wrong to prevent it happening again is of critical importance. Ongoing analysis of complaints and incidents allows the Trust to identify areas that require improvement and highlights systemic issues. Robust investigations are key to this so that the route cause and contributory factors are all identified so we can ensure that the changes that will make the biggest difference are identified. The Trust takes a proactive approach that fosters a culture of continuous improvement. One of the Trust's identified quality priorities for 2023/24 is to create conditions for staff to feel psychologically safe. This promotes a culture focused on learning and improvement, not individual blame.

During this year the Trust has developed a Learning Framework. The Framework sets out how learning will be identified, triangulated, disseminated, and implemented in practice in order to facilitate and embed a culture of appreciative enquiry, to continually improve the Trusts healthcare services.



The Framework shows examples of how learning can be captured and shared, including sharing learning at professional forums, team meetings, Trust-wide communications and using learning and post-reflective events following incidents to bring staff together to learn from each other's perspectives.

The Learning Framework encourages a Just Culture which avoids blaming individuals and looks at issues with the system. This culture encourages managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way.

Velindre Cancer Service – Learning & Improving

Theme: ***Administrative processes including communication***
Issues identified: - A number of patients have reported difficulty in contacting the Cancer Centre by telephone, or not receiving responses to answerphone messages left. - Patients reported that appointment time and location changes were not communicated in a timely manner. - A review of documentation systems identified delays in sending clinical letters to GPs, and that patients were not routinely copied into letters. - Several patients experienced treatment delays due to issues with referral processes.
Learning identified: - There was variation in practice within the Trust's administrative processes - Demand on the Cancer Centre, combined with staffing issues meant that pressure on services was impacting on the ability of staff to complete processes in a timely

manner

- The Cancer Centre telephony system is outdated and requires updating

Action taken:

- A review of telephony systems and arrangements has taken place. Updates were made to answerphone messages to ensure patients have clear instructions for who to contact.
- Several Root Cause Analysis investigations have been undertaken, with recommendations made to the service for improvements. Action plans have been created, and work is underway to strengthen referral processes.

Theme: Monitoring of blood results for Systemic Anti-Cancer Therapy patients

Issues identified:

There was a lack of process to ensure unwell patients' blood results were reviewed in full during the on-call period.

Learning identified:

More robust procedures for the monitoring of Systemic Anti-Cancer Therapy patients' blood results were required, to ensure that these are acted on in a timely fashion.

Action taken:

- Investigations were carried out into the issues with the timely monitoring of blood results.
- Additional blood results have been added to the clinical system used to record chemotherapy care.
- Clinical assessment documentation and escalation pathways have been strengthened.

Theme: Systemic Anti-Cancer Treatment Helpline issues

Issues identified:

- The number of 'out of scope' calls to the Treatment Helpline was affecting the timely response to Systemic Anti-Cancer Therapy patients.
- The triage tool used by Helpline staff was not sufficiently robust and required updating.

Learning identified:

A more robust triage and escalation process for patients is required to ensure patients calling the helpline when unwell are directed to appropriate care as soon as possible.
Action taken: - Enhanced Systemic Anti-Cancer Therapy training for staff will now include assessing and completing the UK Oncology Nurses Society triage tool. - Development of an escalation pathway for patients requiring urgent medical reviews. - An external peer review was commissioned into the Treatment Helpline, with a number of recommendations for improvement made. Areas of good practice were identified. - Work has been undertaken to ensure that patients calling the Cancer Centre are directed to the appropriate department, to reduce the number of 'out of scope' calls to the Treatment Helpline.

Theme: Outpatient waiting times
Issues identified: Patients have fed back to the service that waiting times in outpatient areas are too long
Learning identified: - Ways of working - Environmental factors
Action taken: - Additional room capacity has been made available to increase the number of patients who can be seen at once. - Communication with patients about possible delays have been improved.

Welsh Blood Service – Learning & Improving

Theme: Improvements to the donation environment
Issues identified: Based on feedback from donors, a number of issues were affecting donor comfort at remote venues around Wales.
Learning identified:

- The temperature of the donation venues was not always comfortable for donors, being either too hot or too cold. - The provision of gluten-free and vegan snacks was requested by donors. - The presence of flies was an issue at one venue. - Donors experienced parking issues at some venues.
Action taken: - Fans that can produce hot or cold air have now been provided to blood collection teams. - Gluten-free and vegan snacks are now routinely provided. - Communication about car parking arrangements at venues is now sent to donors in advance of appointments.

Theme: Donor feedback collection
Issues identified: - Following the return of mobile blood collection teams, after the Covid-19 pandemic, no electronic means for donor feedback capture was available. - A lack of connectivity at remote collection sites was affecting the ability of staff to collect donor feedback using devices
Learning identified: Devices and remote connectivity were required for staff to collect donor feedback at remote sites.
Action taken: Teams have been provided with tablets to utilise the CIVICA donor experience system.

Priorities for 2024/2025

The Trust will build on its successes in the 2023/2024 period and continue to learn and improve in line with both feedback from those we serve, and the findings of our own internal work to identify opportunities to improve the quality of our services.

- Our new Learning and Incident Management Frameworks promote a compassionate approach to staff, donors and patients involved in safety incidents. We will work with

colleagues to ensure the frameworks are embedded in our organisational culture, focusing on support, proportionality and a no blame approach.

- When things go wrong, we will conduct proportionate investigations in a timely manner, ensure we learn from what happened and take action to improve our services.
- Utilising the knowledge from our complaints training and ensure that our complaint responses are equitable, and opportunities are taken to identify people who require reasonable adjustments at the earliest opportunity. We aim to ensure our complaints process is accessible to all. Building on the learning from our recent training, we will make our complaints process more accessible at all stages to those who require reasonable adjustments. This includes providing information in a variety of formats, and tailoring our response to the requirements of the person who has raised a complaint.
- To develop a Civica survey to elicit feedback from people who raise concerns to identify areas to improve our complaints handling process.
- To build on the improvements we have made in 2023/24 in the timely managements of safety incidents.
- To develop digital storytelling as a way of capturing feedback and learning to improve our services. Digital story telling involves the development of recorded video and audio pieces to help patients, donors and our staff to share their experiences.
- To further develop ‘Always On’ reporting metrics in line with the Duty of Quality requirement. Always On reporting allows our patients, donors, staff, and the wider public to access key measures of our performance in near real time.