Patient Experience Report
February 2021

This report provides information on Patient Experience, Risk & Legal Services what it means and how we are using it to improve the service. Included within this report is the current performance of the Health Board's Service Groups and learning.

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1. PATIENT EXPERIENCE UPDATE

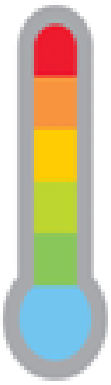
Due to Covid-19, the collection of the Friends and Family paper forms has been suspended from 23rd March until the Covid situation improves.

For the month of January there were 806 Friends and Family online survey returns which resulted in 88% of people stating they would highly recommend the Health Board to Friends and Family which was a 9% increase from January 2021.

From the 806 responses received the high response areas across the reporting period (all with 100% positive feedback) included:

- Bay Blood Testing – Singleton Hospital (269 responses)
- Clinic B1 – Singleton Hospital (9 responses)
- Phlebotomy – Singleton Hospital (8 responses)
- Ward 09 - Singleton Hospital (17 responses)
- Cardiac Rehabilitation - Morriston Hospital (6 responses)
- West Ward - Gorseinon Hospital (4 responses)
- Ward M – Morriston Hospital (11 responses)
- Antenatal Clinic – Singleton Hospital (7 responses)
- Cyril Evans Ward – Morriston Hospital (5 responses)
- AMAU East - Morriston Hospital (4 responses)

The 10 lowest scoring (Below 90%) areas for the reporting period (1st February to 28th February 2021) were:



- Ward 12 - Singleton Hospital (67%) (3 responses)
- Breast Care Unit – Singleton Hospital (60%) (5 responses)
- Audiology Unit - Singleton Hospital (50%) (2 responses)
- Plastic Surgery Outpatients Department – Morriston Hospital (50%) (2 responses)
- CDU Medicine – Morriston Hospital (40%) (5 responses)
- Anglesey Ward - Morriston Hospital (33%) (21 responses)
- Audiology Unit – Morriston Hospital (30%) (10 responses)

- Radiotherapy Unit – Singleton Hospital (18%) (28 responses)
- Ward R - Morriston Hospital (14%) (7 responses)
- Audiology Unit – Neath Port Talbot Hospital (8%) (12 responses)

Each of the Service Delivery Units (SDU) receives a monthly detailed report identifying the themes and they develop an action plan for improvement at SDU level.

Please see additional appendix regarding findings. Ward H Morriston and Ward D NPT comments are relating to the same patient. Staff are aware of his comments and ward managers are in constant meeting to support him.

Low Scoring Areas in February 2021

- **Ward 12 - Singleton Hospital (67%) (3 responses)**
  Overall, how was your experience of our service?
  2 very good responses and 1 very poor.

  Comments left:
  - Really hard to connect and stay connected!
  - Make it easier to stay connected.

  IT are working on this to try and ensure the internet issues are resolved.

- **Breast Care Unit – Singleton Hospital (60%) (5 responses)**
  Overall, how was your experience of our service?

  1 very good response, 2 good responses and 2 neither responses.
  There were no comments left.
  The reason for this low score is due to the 2 neither responses. These bring the scores down.

- **Audiology Unit - Singleton Hospital (50%) (2 responses)**
  Overall, how was your experience of our service?
  1 very good response and 1 neither.
  Comments left:
  - Lovely, caring and helpful staff.

  The reason for the low score is the 'neither' response. As there were only 2 responses this brought the score down to 50%.

- **Plastic Surgery Outpatients Department – Morriston Hospital (50%) (2 responses)**
  Overall, how was your experience of our service?
  1 very good response and 1 neither response.
  There were no comments left.
  The reason for the low score is the 'neither' response. As there were only 2 responses this brought the score down to 50%.
- **CDU Medicine – Morriston Hospital (40%) (5 responses)**
  Overall, how was your experience of our service?

2 very good responses, 1 neither response, 1 don't know response and 1 poor response.
Comments left:
 Wi-Fi connection not good and most of the time it doesn't work
IT are working on this to try and get the internet issues sorted.

- **Anglesey Ward - Morriston Hospital (33%) (21 responses)**
  Overall, how was your experience of our service?
  7 very good responses, 11 don't know responses, 2 neither responses and 1 poor response.
  Comments left:
  - Waiting time
  - Very friendly
  - Great listener

  The number of don't know and neither responses have brought this score down.

- **Audiology Unit – Morriston Hospital (30%) (10 responses)**
  Overall, how was your experience of our service?
  3 very good responses and 7 don't know responses.
  Comments left:
  - Staff need to follow markers in corridor and not walk into patients. If patients are made to do it surely staff should.
  - It was great.

  The feedback has been passed onto the ward.
  The number of don't know responses has significantly brought down the recommendation score.

- **Radiotherapy Unit – Singleton Hospital (18%) (28 responses)**
  Overall, how was your experience of our service?

  4 very good responses, 1 good response and 23 neither responses.
  Comments left:
  - Clear cheerful and polite

  The reason for the low score was due to the 23 'neither' responses. There were no negative comments left to indicate a bad experience.

- **Ward R - Morriston Hospital (14%) (7 responses)**
  Overall, how was your experience of our service?
  1 good response, 4 don't know responses and 2 very poor responses.
  Comments left:

  These comments have come from a complainant who has sent in multiple friends and family forms along the same lines as this. They have been sorted with the ward.
  The IT issues have been passed to IT.

- **Audiology Unit – Neath Port Talbot Hospital (8%) (12 responses)**
  Overall, how was your experience of our service?
  1 very good response and 11 don't know responses.
  There were no comments left.
  The 11 don't know responses brought the score down significantly.

1.2 Patient Experience Team Work

Civica Update: The New Patient Feedback System is set to launch 1st April. This will replace the current SNAP system. Patient Experience staff meet weekly with the new provider Cirvica. We have move in to Phase 1, set up. IT department also meeting weekly to ensure seamless process.

Dates to remember:
Snap system to be close 31st March
F&F & All Wales Surveys close 26th March
Bespoke surveys to close 26th March
SMS covid survey to close 17th March
iPads removal link 26th March

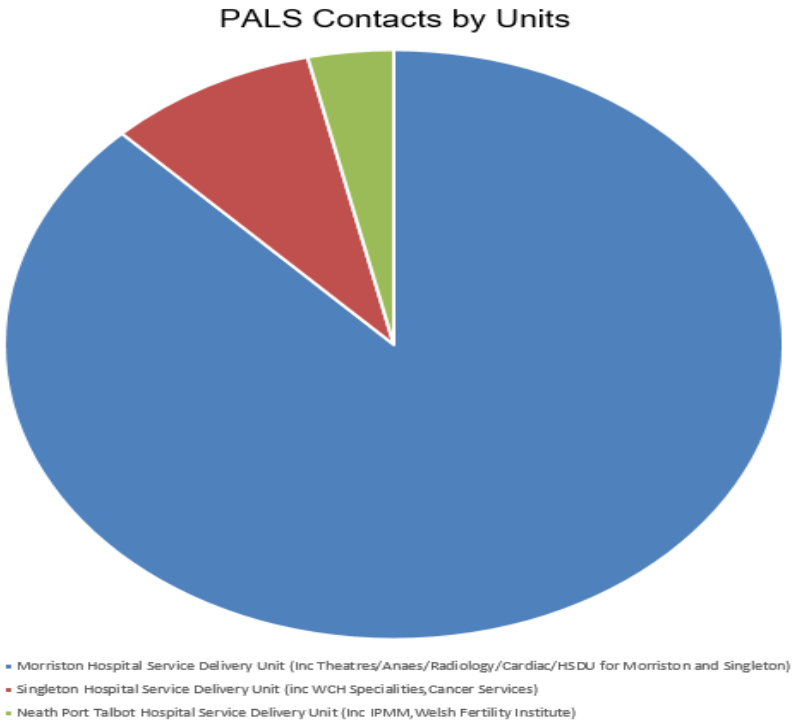
There maybe a few days/weeks where we are unable to collect feedback data. This has been reported in the corporate risk register.

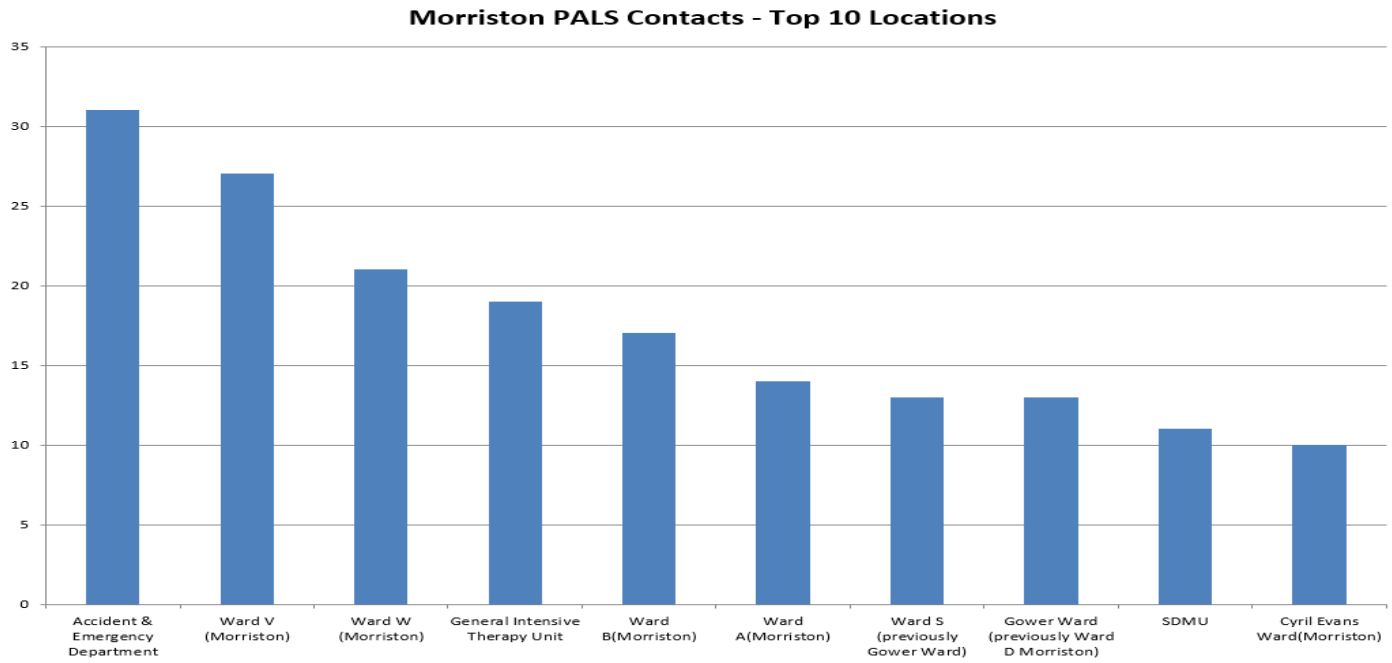
Please note: The new system will only house the historic data for the last finical year 2020/2021. Feedback before that date range will be in the format of a CSV file. The Snap master CSV file will be saved and kept with Patient experience team for any requests for feedback from 2014 – 2020.

1.3 Patient Advisory Liaison Service (PALS) Activity – February 2020

During the month of February 2021, the Health Board's PALS Teams recorded 366 records on the Datix system, this compared to a total of 172 contacts for February 2020.

These are broken down by each PALS Team/Delivery Unit below, Morriston having the highest number with 321 contacts.

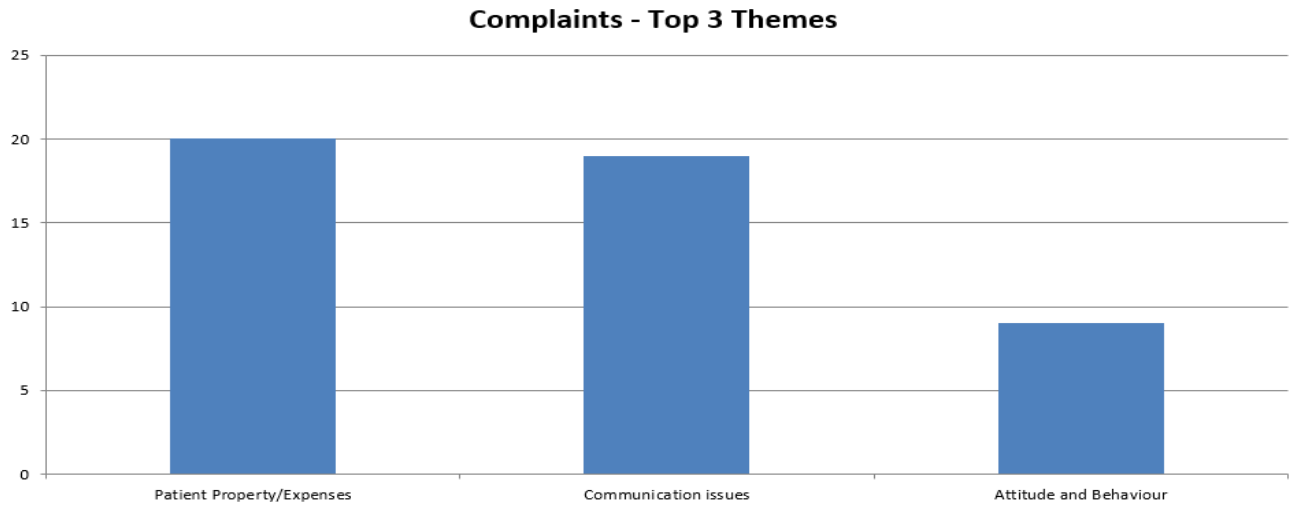




The PALS teams deal with a variety of different situations ranging from complaints to compliments, below shows the contacts by type;

Advice	5	**Concern**	78
Bereavement	53	**Help**	20
Comment	4	**Information**	54
Compliment	25	**Support**	127

Out of the 78 concerns received via the PALS Team, the top complaint issues are below;



Communication training for all staff

As a result of the themes emerging from the PALS report we have developed bespoke communication training for all staff.

1.4 All Wales Patient Experience Questionnaire – 81 returns

The results below are captured through the Patient Experience Framework questionnaire.

Reduced numbers of returns due to Covid

Percentage of patients that ticked 'Always' to the following questions:											
Treated with Dignity?											
Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
97%	100%	100%	92%	92%	93%	88%	96%	96%	65%	90%	96%

You were given help with feeding and drinking											
Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
0%	100%	0%	0%	80%	40%	76%	75%	100%	50%	86%	83%

Were you given the support you needed to help with any communication needs?											
Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
98%	100%	93%	82%	87%	89%	83%	90%	100%	64%	89%	89%

Were things explained to you in a way that you could understand?											
Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
93%	95%	100%	92%	94%	87%	76%	89%	89%	76%	90%	92%

Did you feel we did enough to keep you as free as possible from pain?											
Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
75%	100%	100%	67%	89%	79%	85%	81%	76%	60%	80%	83%

People are kind and compassionate to you?											
Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
92%	100%	100%	78%	92%	96%	81%	91%	81%	67%	86%	87%

People are welcoming, friendly and helpful?											
Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
88%	100%	100%	67%	90%	91%	83%	96%	81%	67%	86%	87%

Percentage of patients that ticked 'Never' to the following question:											
At any point in your stay did any of our actions make you feel unsafe?											
Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
88%	100%	80%	67%	86%	83%	84%	71%	86%	70%	80%	84%

2. LEARNING FROM FEEDBACK

The Health Board uses feedback from incidents, complaints, Friends and Family questionnaires and systems such as “Lets Talk” and “Care Opinion” to learn following feedback from patients, relatives and staff.

‘Let’s Talk’ – February 2021

The Datix Risk Management system is used to log, store, and track the Swansea Bay Lets Talk data/information. This enables the Health Board to use this data when looking at themed reports. For February there were 59 contacts. 12 were converted to complaints; 1 compliment and 2 referred back to the GP/dental practice. The remaining related to queries which PALS managed, Vaccine correspondence and marketing emails/ accidental pocket calls.

‘Social Media’

0 received

There were no comment from Care Opinion for February 2021

I Want Great Care

There was no feedback on I Want Great Care in January.

2.1 Learning from Events

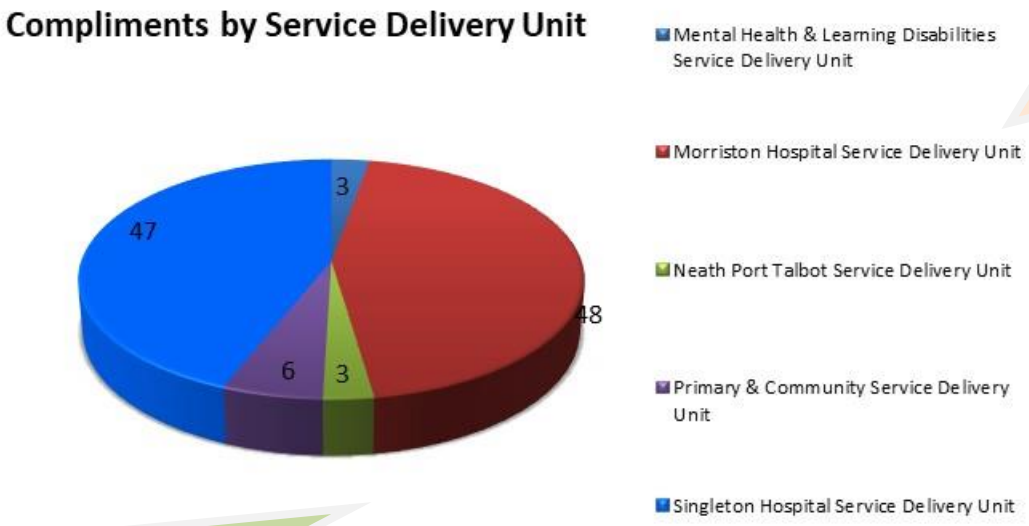
This section of the report will include learning from events for example: SI’s, incidents, complaints, claims, inquests and Redress cases. The Learning from Events will be issued using the RL Datix alerts module to ensure the Service Groups receive them.

The NHS Delivery Unit issues the first leaning brief nationally from NHS organisations reporting learning from Covid-19 cases: **CoRSEL learning update #1** To all HBs/Trusts. The update provided a summary of **early learning** related to in-hospital transmission of Covid-19. The learning brief has been shared with Covid Gold members and distributed to Units through the Datix Alerts module.

3. COMPLIMENTS

A total of 107 compliments were recorded on Datix between 1st February 2021 and 28th February 2021, a breakdown by the Delivery Units is provided on Page 14 and a selection of compliments received.

3.2 Written Compliments – February 2021



"Just a thank you to everyone who helped us bring our long awaited baby home! She is now 4mths old and doing amazing.
Huge thanks to the nurses for the endless encouragement at the scan appointments, and making me laugh even at egg collection and even the voice of friendship from the admin team. Not forgetting the ear of the counselling service too. So glad that our little girl was "put back in the right place" and it worked". **Welsh Fertility Institute, Neath Port Talbot Hospital**

"Words cannot express my gratitude for all of the tireless compassion that you have given to xxxx during their long stay with you at Llwyneryr Hospital. Especially during this horrible pandemic due to Covid-19. I would like to thank all of you from the bottom of my heart. Without your extraordinary and untiring support it would never have been possible for xxxx to be where they are today".
Llwyneryr Assessment and Treatment Unit, Mental Health & LD

"I would like to extend my sincere thanks at the support and care I received from the night staff on A and E ward. An auxiliary nurse and nurse worked tirelessly in a particularly demanding environment. They both took excellent care of me and were highly professional. In addition, at 10.30 I was moved to RAU and again the help, support and care I received was excellent from my auxiliary and nurse at night and during the day. The doctors on duty there were nothing short of outstanding in taking care of me and finding out what was going on such a busy ward. I was present when a patient went in cardiac arrest and the whole team dealing were fantastic and prompt in saving that patient's life".
Accident & Emergency Department, Morriston Hospital

"Without exception every member of staff on Ward 2 was professional, incredibly hardworking and extremely kind - this last point is crucial. I felt fearful and vulnerable going into Singleton, after returning from theatre I felt safe and secure, and above all, confident that I was in the hands of amazing people. I will always remember the acts of kindness I experienced on Ward 2. I cannot thank those lovely people enough. I honestly feel privileged to have been a patient at Singleton Hospital". **Ward 2, General Surgery, Singleton Hospital**

"Hi just to send email to say thank you very much for your help and support such as this difficult time you guys are doing amazing work in such a difficult time thanks for looking after us I pray for you God bless you. "

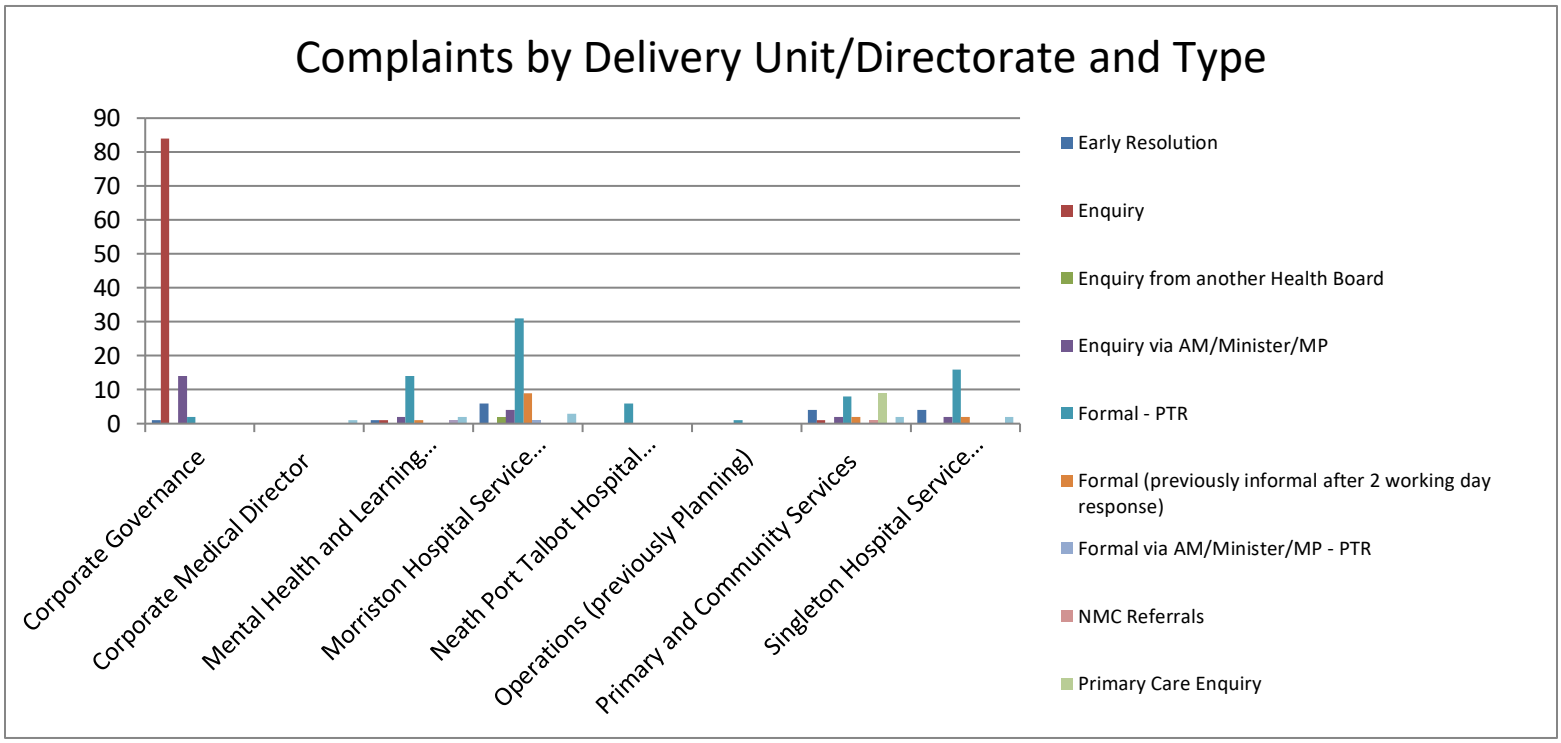
Artificial Limb and Appliance Centre, Primary Care & Community Services

4. CONCERNS MANAGEMENT

4.1 Complaints – February 2021

Complaints 1.2.21 – 28.2.21

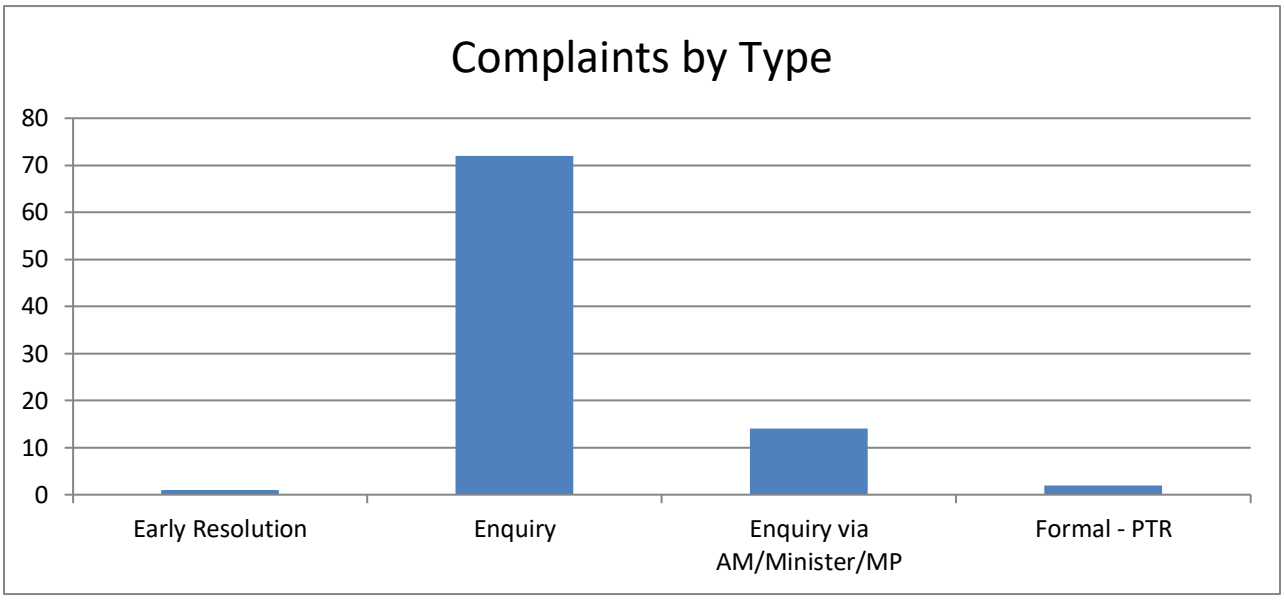
The Health Board received 242 complaints during the month February 2021, please see breakdown by unit and type below;



Out of these 242 complaints, 100 related to COVID-19, please see subject breakdown below;

Bay Field Hospital Incident	1
Acquired COVID-19 during admission	2
Infection Control (contamination)	2
Access to other treatment	93

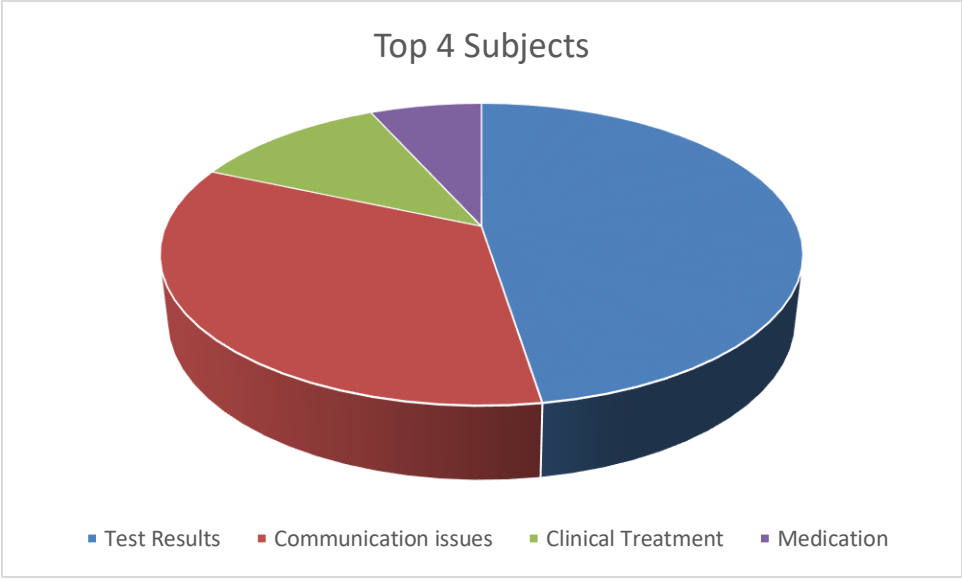
During February 2021, the Health Board received 89 enquiries/complaints regarding the COVID-19 Vaccine, see breakdown of type below;



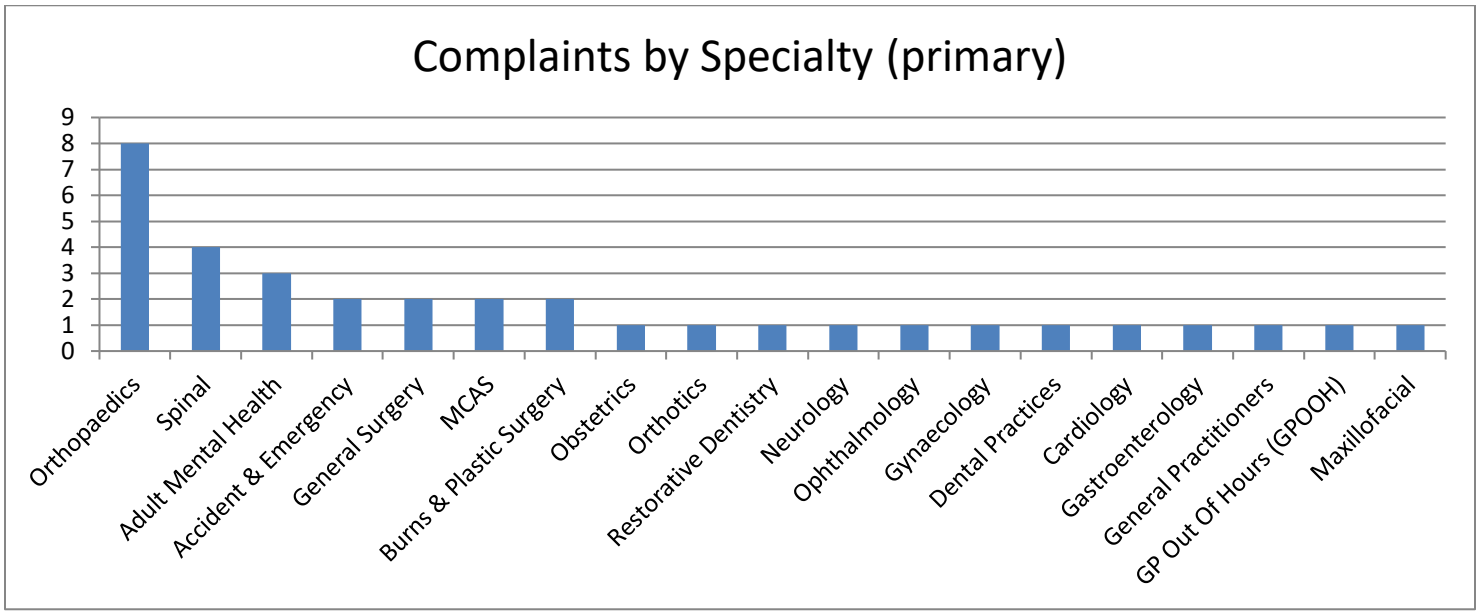
14 of these were received via AM/MP's, which are monitored on a weekly basis to ensure they are responded to in a timely manner.

The Complaints Team are currently supporting the Vaccine Enquiry Inbox, they are reviewing all communications into the Health Board and ensuring that they are responded to in a timely manner.

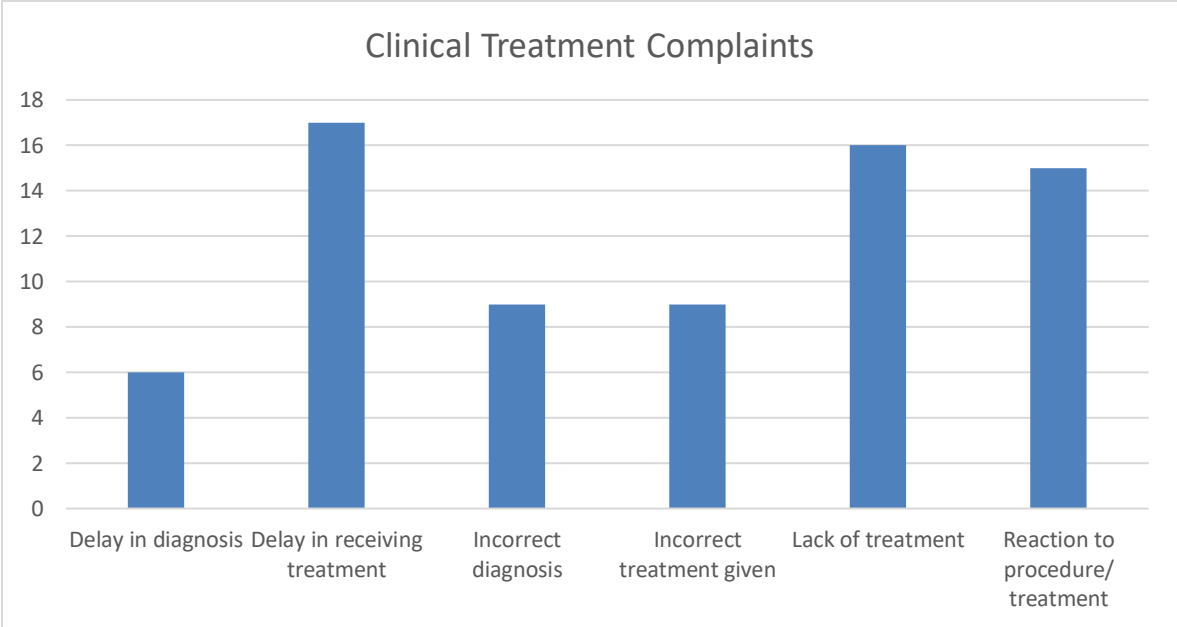
Top 4 Complaint Themes



During February there were 32 complaints received which related to cancelled or delayed appointments or admissions. Please see breakdown by specialty below, as you can see Orthopaedics received the most complaints;



Clinical treatment is one of the top subjects therefore, please see further breakdown below;



4.2 Concerns Assurance

On a monthly basis, the Health Board conducts a Concerns Redress Assurance Group (CRAG) where the Corporate Complaints Team review recently closed complaints. A 'deep dive' review is undertaken on each Service Groups in turn, as well as the review of a selection of closed complaints from the other Service Groups. During this review, any agreed actions by the Service Groups are monitored by the Corporate Complaints Team to confirm actions are completed to ensure compliance. CRAG is

continually developing and evolving to ensure that the best possible learning and assurance is attained by the Health Board.

A CRAG meeting was held with Mental Health & Learning Disabilities Unit on 9th February 2021 and was attended by the Unit Nurse Director. The review was positive and the new restructure was discussed.

As part of this CRAG meeting ,held with the Mental Health & Learning Disabilities Unit following a recent letter received from the Community Health Council (CHC) advising that complaint letter had been provided to a Complainant that was not PTR complainant. The current issues identified and the requirement for PTR compliance was fed back at this review.

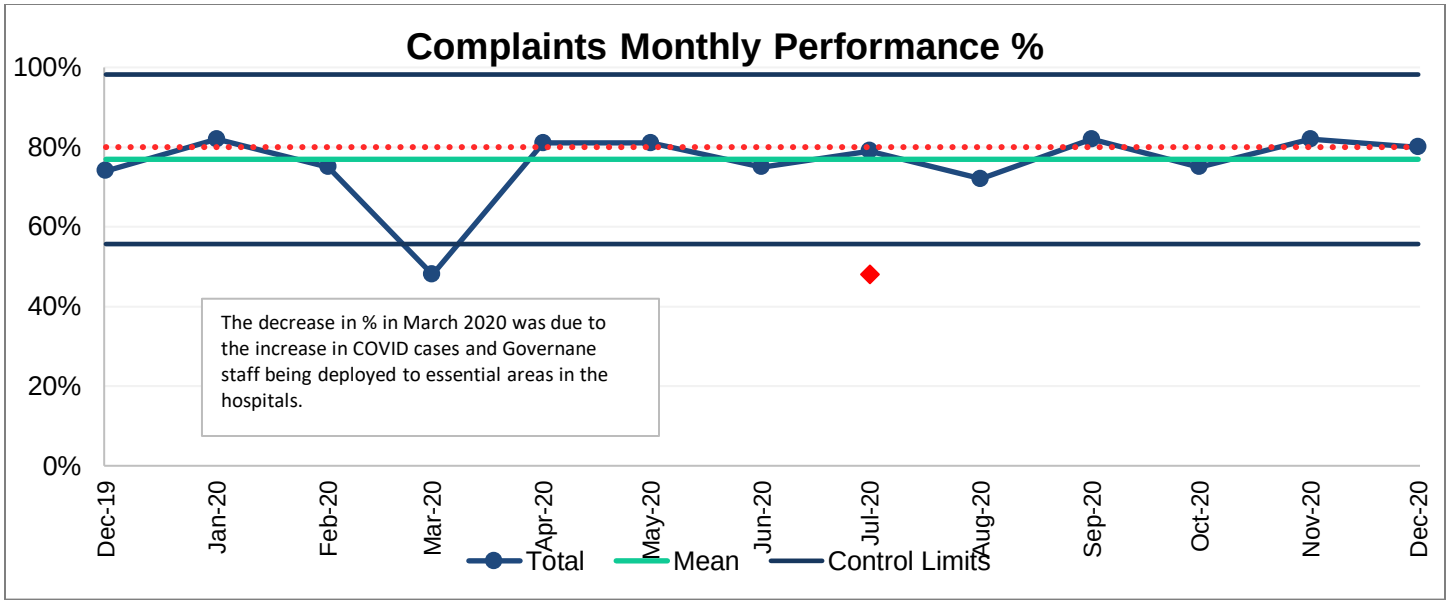
Current concerns regarding the Mental Health & Learning Disabilities cases:

- Letters of complaint are sent out to the Locality Managers & are not returned to the Governance Team, this results in PTR not being considered and often letters which should be run past the Legal Team for Redress advice are not as the Q&S Team do not receive the responses back for review/consideration of whether there has been a breach of duty.
- Responses could be far more apologetic and sympathetic. Opening the letter with 'I am disappointed you had cause to complain about the treatment' often gives the wrong impression from the outset.
- Responses often do not read well and are often defensive.
- Responses often do not offer the complainant sympathy for the loss of their family member.
- Delays and lack of updates often unfortunately lead to complainants having no faith in the Health Board's investigation.
- If complaints go to the Ombudsman, the Health Board will be criticised for not providing regular updates to the family, which may result in financial penalties also.
- The opportunity to build bridges with families at this point, who advise in their complaint the effect of the care provided has had on them as a whole, as well as the patient
- Families are often very open and honest and we often lose the opportunity to put things right at this point, which leads to the families going to the Ombudsman or sadly feeling let down.

The Complaints Department will deliver training via TEAMS Learning Event will be rescheduled in Q3/Q4 of 2020/21. The Complaints Department will keep the Units up to date with newsletters which will identify themes from complaints/learning and good practice in terms of complaints management have been issued.

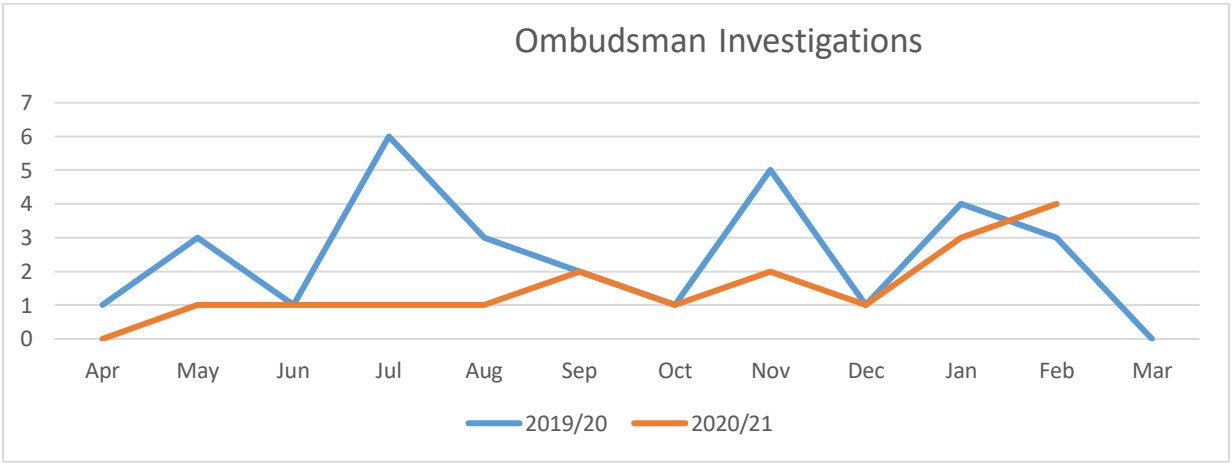
4.3 Complaints Performance

The Health Board recorded 80% performance against the 30 working day target in December 2020. The Welsh Government Target is 75%. The significant decrease in performance in March was due to the current COVID-19 situation with staff in the units being unable to undertake their usual governance roles. The overall performance against this target in 2019/20 was 82%.



4.4 Ombudsman Cases

There has been a slight decrease in complaints which the Ombudsman has investigated in relation to the Health Board in 2019/20, 30 compared to 44 in 2018/19. There were four new investigations received during February 2021.



The Ombudsman will be providing Complainants Standards Training to all Governance Teams on 9th and 18th March 2021. There is no charge for the training and it will be of great benefit to the Health Board. The training has already been successfully delivered to Local Authorities and will now continue to be rolled out on an All-Wales NHS basis.

4.5 Concerns Actions taken/being taken include:

- Concerns Redress Assurance Group (CRAG) to continue reviewing and auditing complaint responses to ensure compliance with the "Regulations".
- Each month a 'deep dive' review is undertaken on each Service Delivery Unit in turn, as well as the review of a selection of closed complaints from the other Service Delivery Units. During this review, any agreed actions by the Service Delivery Units are monitored by the Corporate Complaints Team to confirm actions are completed to ensure compliance and reported to the Quality and Safety Governance Group.
- Attendance at both Ombudsman & Complaints Network Meetings will continue throughout 2021. These meetings are currently being undertaken and attended remotely.
- Two Complaints Newsletters have been issued, which include learning from Ombudsman cases, PALS work and management of complaints.
- Further work with the Ombudsman Office to take place in relation to introducing Complaints Standards Training.
- All-day Ombudsman Complaints Standards Training will be proceeding on 9th and 18th March 2021. The will be the first sessions delivered with further sessions to be arranged.

4.5 Incidents

4.5.1 Incident Reporting & Performance

For the period 1 February 2021 to 28 February 2021, a total of 1,654 incidents were reported (January was 1646). The severity of the level of harm of incidents reported is set out as follows:

Severity of Harm	Incidents Reported
No Harm (1)	1245
Low (2)	319
Moderate (3)	71
Severe (4)	3
Death (5)	16
Total	**1654**

The top five themes relate to:

Incident Type Tier One - Top 5	No	
Injury of unknown origin	274	16.56%
Pressure Ulcers	239	14.44%
Patient Accidents/Falls	196	11.85%
Behaviour – Patient affected	129	7.79%
Behaviour (including Violence and Aggression) – Staff affected	114	6.89%

The Health Board has improvement programmes in place for Pressure Ulcer incidents and Falls (these Groups oversee all these incidents) and the results/performance of these programmes are detailed in performance reports to the Quality & Safety Governance Group.

Behavioural incidents are reported and monitored through the Health and Safety Operational Group and reported to the Health and Safety Committee.

In terms of the incidents relating to unknown origin, analysis of the 274 incidents recorded is as follows:

- All incidents affected patients
- None were reportable to the WG

The types of incident are below:

Incident type tier three	Data
Non SBUHB acquired Moisture lesion	113
SBUHB acquired Moisture lesion	85
Injury of unknown origin	76
Total	**274**

Staff will record the following as an injury of unknown origin:

- Blisters
- Injuries where it is not known how they occurred (eg, skin tears)
- Bang on bed rails
- Injuries caused by trauma not pressure
- Diabetic/leg Ulcer
- Haematoma

Scrutiny of these 76 cases identified 16 incidents which had been incorrectly coded. These cases have now been updated and coded correctly as follows:

Bed Availability	1
Pressure Ulcer	7
Patient Accident/Fall	3
Medication	1
Moisture Lesion	4

Consideration is being given to how health organisations in Wales classify these incidents to ensure consistency as part of the Once for Wales Work.

Incidents overdue for closure (the 30 working days for completion of the investigation has passed) at 4 March 2021

- There are 2904 incidents (48 of which are Redress)

After 1 April 2021, there will be a window of 3 months to close cases down, before the system is made read-only. All live cases that remain on the current system after this time will need to be transferred manually to the new Cloud system. Units will be asked to analyse this data and undertake incident closure where possible.

Delivery Unit/Directorate	No
Morriston Hospital Service Delivery Unit	1070
Singleton Hospital Service Delivery Unit	631
Mental Health and Learning Disabilities Delivery Unit	582
Primary & Community	305
Neath & Port Talbot Service Delivery Unit	153
Operations	77
WOD	28
Corporate Governance	37
EMRTS	8
Corporate Medical Director	3
Nursing & Patient Experience	4
Princess of Wales Service delivery Unit	5
Finance	1
Total	2904

4.5.2 SI's Reported 1st February 2021 to 28th February 2021

During the pandemic, Welsh Government changed the SI reporting criteria, reported to the Q&SGG in March 2020, however, this then reverted back to the criteria that was in place prior to COVID. Due to the second surge in COVID cases, the Health Board received a further letter from Welsh Government dated 4th January 2021 to advise that due to current pressures, they have now changed the criteria back to the limited reporting of Serious Incidents. Only the following require reporting;

- all never events
- in patient suicides
- maternal deaths
- neonatal deaths
- homicides
- incidents of high impact / likely to happen again including child related deaths (for local decision)

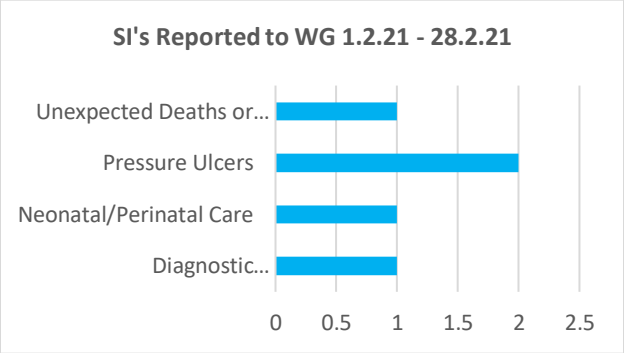
- Covid-19 nosocomial transmission; these do not require reporting individually as SI's but will continue to be CORSEL reported

- **From 1st October 2020** all SI's will be reported to the NHS Delivery Unit who have taken over responsibility for reviewing new SI's and assuring the closure forms. No Surprise Reports will still be reported to Welsh Government. From a Health Board perspective, the Serious Incident Team have reviewed and updated their reporting processes. The Service Groups processes will remain unchanged as they report SI's and NSR's to the Serious Incident Team.

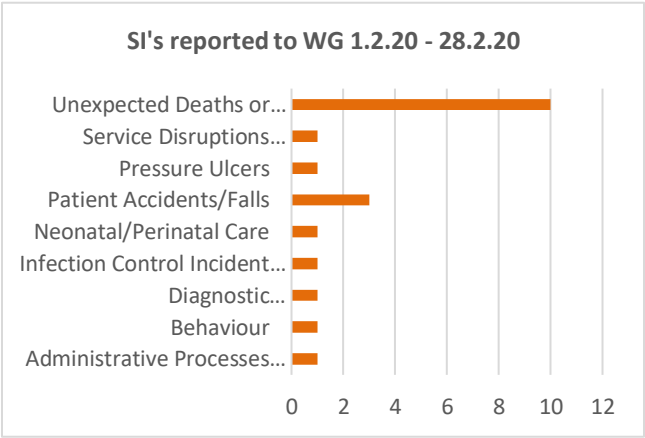
- As a reminder **CORSEL** is in place which requires the Health Board to identify learning from Covid cases to be shared with Health Boards via a report to the NHS Delivery Unit. All notifications are to be sent to the Health Boards Serious Incident Team for reporting.

- During February 2021 a total of 5 serious incidents were reported to Welsh Government, see breakdown below;

SI's reported 1.2.21-28.2.21	
Diagnostic Processes/Procedures	1
Neonatal/Perinatal Care	1
Pressure Ulcers	2
Unexpected Deaths or Severe Harm	1



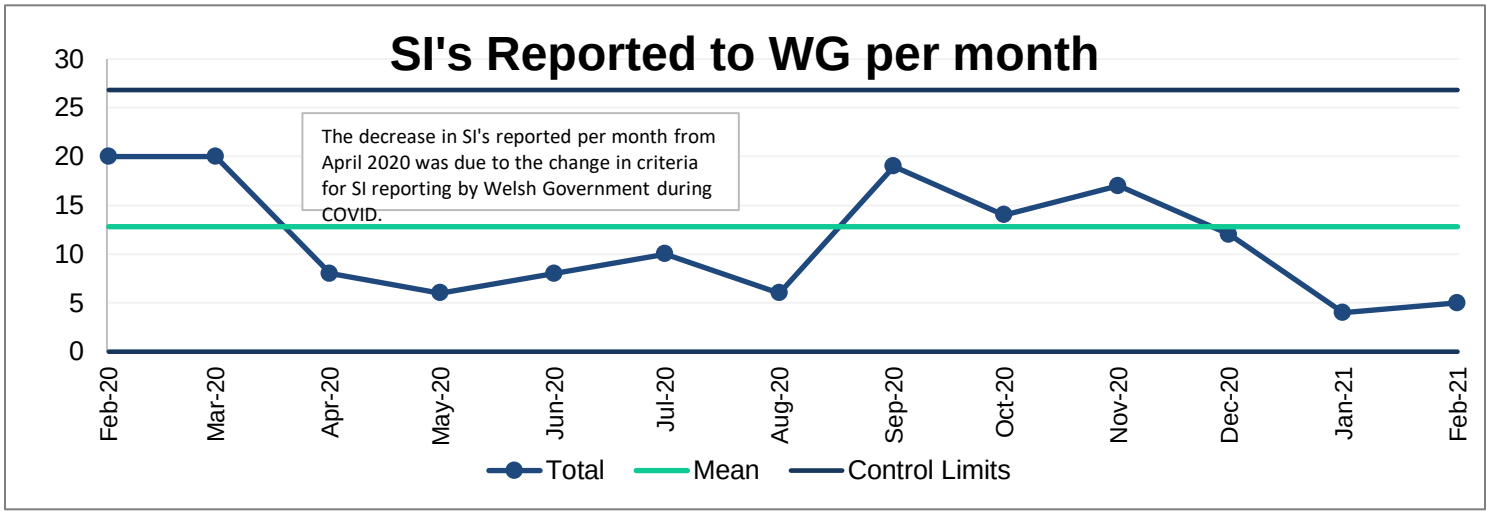
SI's reported to WG 1.2.20 - 28.2.20	
Administrative Processes (Excluding Documentation)	1
Behaviour	1
Diagnostic Processes/Procedures	1
Infection Control Incident (Healthcare Associated Infection)	1
Neonatal/Perinatal Care	1
Patient Accidents/Falls	3
Pressure Ulcers	1
Service Disruptions (environment, infrastructure, human resources)	1
Unexpected Deaths or Severe Harm	10



In comparison, the number of serious incidents reported to Welsh Government was higher in February 2020 with 20 Serious Incidents reported. Serious incidents reported on a monthly basis are set out in the graph below by month. During the month of February 2021 the Health Board reported 5 Serious

WG changed the criteria to limited reporting due to COVID again in January which again explains the decrease in reporting

Incidents.



Learning from SI's

The Serious Incident Team will produce a Learning brief from the Serious Incidents they investigate which will be issued via RL Datix, alerts module. The SI Team will also support the sharing of learning from SI investigations in relation to themes form SI's for example: falls; pressure ulcer; mental health cases and infection control. The Learning briefs will also be shared with the Quality & Safety Committee.

4.5.2 Never Events

The last Never Event was reported to Welsh Government on the 19th November 2020 (Wrong implant/Prosthesis). During 2019/20 the Health Board reported seven never events to Welsh Government relating to:

- Wrong Implant/Prosthesis
- Retained Foreign Object
- Wrong tooth extraction – two cases
- Wrong site surgery – three cases

The Health Board has investigated these incidents and the learning from the closed cases has been presented to the Quality & Safety Governance Group and Quality & Safety Committee. A Newsletter setting out the learning and actions taken will be issued in Q3 of 2020/21.

Actions

- SI training to be delivered across the Health Board in accordance with training programme and;
- Never Event Newsletter to be issued in Q3.

Never Events during 2019/20

During the year seven incidents occurred which were a 'Never Event.' They are incidents that all NHS organisations should have robust systems and processes in place to prevent them occurring. The

incident has been fully investigated and as a result changes have been made to improve patient safety. The event related to wrong site surgery.

The last Never Event was reported to Welsh Government on the 19th November 2020 (Wrong implant/Prosthesis). Since 1st April 2020 the Health Board has reported three never events to Welsh Government relating to:

- Wrong Implant/Prosthesis
- Retained Foreign Object

The learning from these event includes:

5. Once for Wales Update

All NHS bodies are required to report incidents on to the Datix software management system. Currently, all Health Boards/Trusts in Wales have varying versions and modules of the DatixWeb and DatixRichClient systems and the Once for Wales Concerns Management System (OfWCMS) will introduce a new cloud-based system from 1 April 2021. The key features of the all Wales RLDatix system include incident management, investigation management, risk and compliance management, audit management, contractor management, controlled-document management, action management and reporting and analysis, with the ability to capture investigations, learn and share information across NHS Wales.

Implementation of the new Once for Wales Datix system is overseen by the SBUHB O4W Implementation Group/Datix User Group which meets monthly and comprises of representatives from across SBUHB.

The 8 modules that are anticipated to be ready for implementation for Phase 1 April 2021.

Module	SBUHB Position
Incidents	The incidents module was due to go live in 2022, however it has been brought forward to April 2021. A report was presented to Quality & Safety Governance Group in January 2021. Due to the scale and complexity of the incident module, and the risk that SBUHB will initially lose functionality within the system a recommendation was made delay going live with the incident module from 1 April 2021.
Feedback (Complaints)	Planned for 1 April 2021
Feedback (PALS/Compliments)	Planned for 1 April 2021
Claims	Planned for 1 April 2021
Redress	Planned for 1 April 2021
Mortality	Awaiting formal confirmation from the National O4W team.
Safeguarding	Awaiting formal confirmation from the National O4W team.
Inquests	Planned for 1 April 2021

The Datix team continue to work to complete tasks to support Phase 1 of the implementation of the new RLD Datix cloud system 1 April 2021.

Updates as follows:

- Once for Wales Implementation group/Datix user group – meet monthly and comprises of representatives from all Service groups and directorates. A staff bulletin providing information on progress with the project has been issued to key staff, which include Frequently asked questions (FAQ's)
- System Hierarchy (Locations/Services) – deadline by 23 December 2020 – The hierarchy as it currently stands was sent to the OFW team on 23.12.2020. When the new hierarchy information has been received, the system will be updated (possibly in June/July 2021)
- User Import Document – list of all staff access/permissions deadline 12 noon 29 January 2021. Datix team have submitted the partially completed document and the remainder of the staff will be added manually when SBUHB have access to the new system
- Combo-Linking – deadline by 29 January 2021. The HB already has combo-linking in place
- Staff contact information – this information was sent to the O4W team by the deadline of 5 February 2021
- Training in the Cloud – The training dates have been set up and advertised on the Intranet, in the Datix Bulletin and the Units notified by e-mail
- Civica software system – work is progressing to implement the new patient experience system through the patient experience team

6. Healthcare Inspectorate Wales

Update on Action Plans from 2019/20 and 2020/2021 HIW Inspections

Inspection	Action Plan Update
National Review of Maternity Services	HIW to meet with HoMs to discuss timescales for completion of improvement plans
NPTH Birth Centre	All actions completed.
Morriston Hospital Paediatric Services	Outstanding Actions (some overdue): 1. Consider ward layout and dignity of patients/parents/carers (Covid-19 delays) 2. Emergency Bell needs to be heard across the ward (Covid-19 delays) 3. MDT working group has been set up re the approach to Sepsis 6 4. Pain Management recording to be audited 5. Review of staffing rotas to take place (by 2021) 6. Appraisals compliance to be addressed (plans in place)
Morriston Hospital ED/AMAU	Complex and detailed action plan which the DoN is sighted on.
Cefn Coed Hospital	All actions completed except the closure of the smoking room on Fendrod Ward. Delayed due to Covid-19 Pandemic.
Cwmafan Health Centre	Two actions outstanding, required by estates. This is included on the HB's Risk Register and actions have been taken to mitigate risk, which is now low due to reduced footfall.
Alfred Street Primary Care Centre	All actions completed
Greenhill Medical Centre	All actions completed
Skewen Medical Centre	All actions completed
Gupta Dental Surgeons	All actions completed. The HB and Dental Practice Advisor (DPA) worked closely with this Practice to develop an Action Plan. HIW confirmed this Practice is no longer a concern following the updates they have received.
Sketty Road Dental	All actions completed

Dunes Dental Care	All actions completed
Neath Teeth Orthodontics	All actions completed
Gorseinon Dental Practice	All actions completed
Health Centre Station Road	All actions completed
Ravenhill Dental Surgery	All actions completed
Cwmbwrla Dental Surgery	All actions completed
Morriston Orthopaedic Surgery	All actions completed
Gorseinon Hospital	All actions completed
Morriston Cardiac Ward	No Improvements required • The health board is advised to consider how it can further support and maintain these staffing arrangements, particularly as the pandemic progresses. • The health board is advised to consider how it utilises space on the ward with a view to provide single sex toilet facilities, where possible.
Singleton Hospital (Oncology)	All actions completed
NPTH Minor Injuries Unit	All actions completed

HIW Inspections

HIW are currently planning their work on a quarterly basis. We are awaiting the new planned quarterly programme.

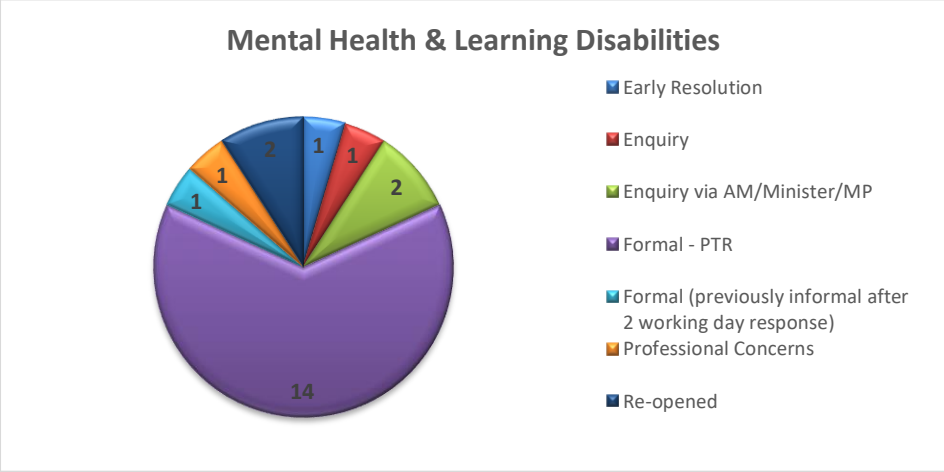
Morriston Hospital (ED) – The HIW Tier 1 quality check originally scheduled for 8 December 2020, has been rescheduled and will take place on 17 March 2021.

7. SERVICE GROUP REPORTS

Mental Health & Learning Disabilities Services Group

1st February- 28th February 2021

Mental Health & Learning Disabilities SG received 22 concerns.



Top Complaint Trends

- Communication (7)
- Discharge Issues (5)
- Attitude & Behaviour (4)

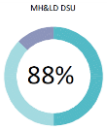
- No Never Events
- 0 Personal Injury claim
- 0 Clinical Negligence claim

Incidents:

246 incidents were reported with the 3 top themes being:

- Inappropriate/Aggressive Behaviour towards staff by patient – (51)
- Inappropriate/Aggressive Behaviour by patient towards patient – (38)
- Self-harming behaviour – (22)

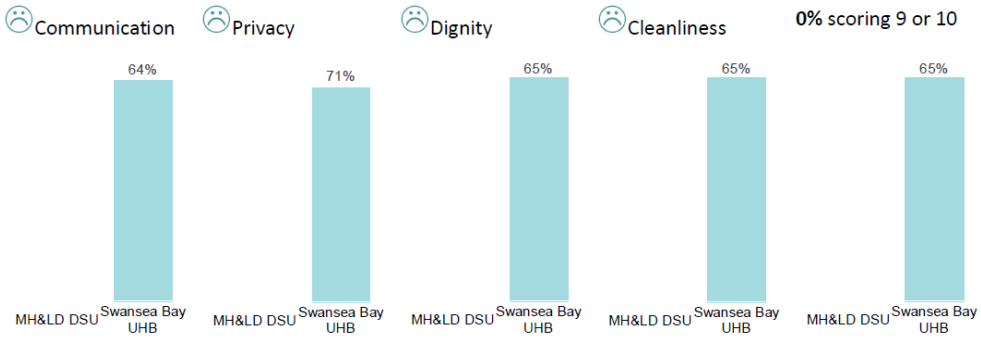
1Serious Incident relating to an unexpected death



Friends & Family Results – February 2021

Of the 8 respondents, 7 said that overall their experience of the service was good or very good.

All Wales Survey

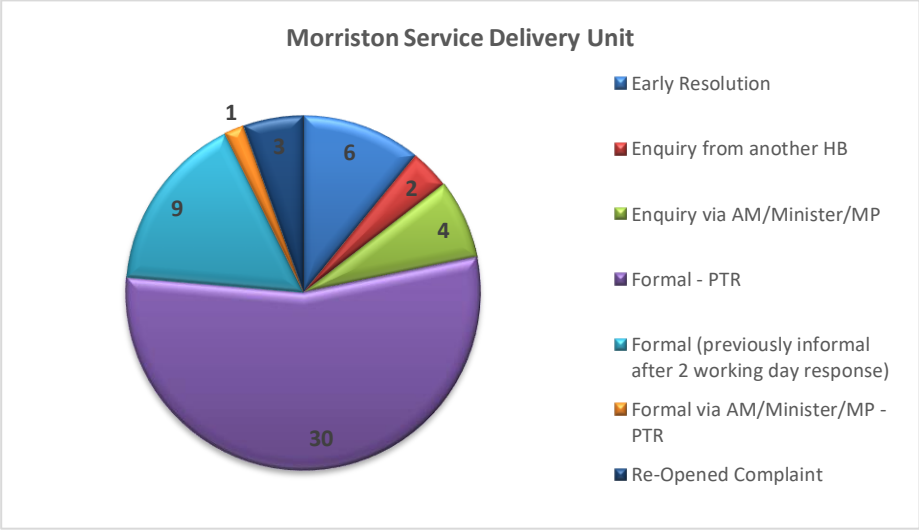


There was 0 All Wales Surveys completed for the Service Delivery Unit during February 2021.

Morriston Hospital Service Group

1st February– 28th February 2021

Morriston Hospital SG received 55 concerns.



Top Complaint Trends

- Communication (17)
- Admissions (10)
- Appointments (6)
- Clinical Treatment (6)

- No New Never Events
- 0 Personal Injury Claims

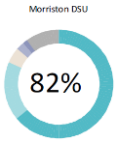
- 7 Clinical Negligence Claims

Incidents:

564 incidents were reported with the 3 top themes being:

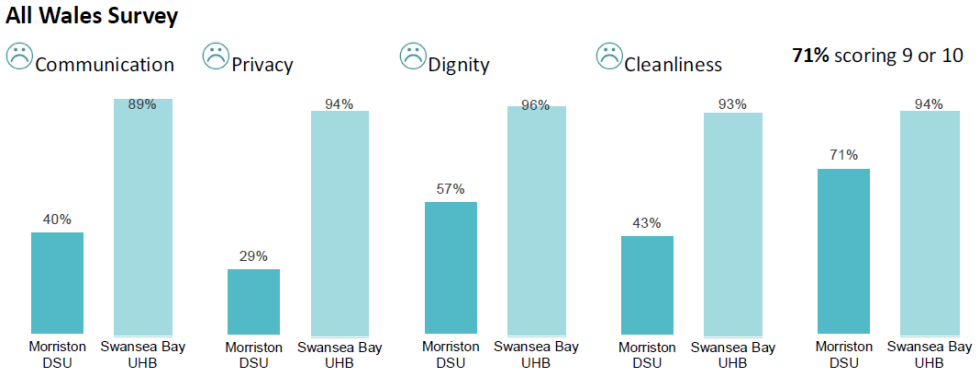
- Moisture Lesion– (75)
- Suspected Slips/Trips/Falls (unwitnessed) – (47)
- Access & Admission – (29)

1 Serious Incidents was reported relating to diagnostic procedures



Friends & Family Results – February 2021

of the 211 respondents, 172 said that overall their experience of the service was good or very good.



7 All Wales Surveys were received for the Service Delivery Unit during February 2021 with the overall score of 71%.

Neath Port Talbot Hospital Service Group

1st February– 28th February 2021

Neath Port Talbot SG received 6 concerns which were all formal PTR

Top Complaint Trends

- Medication (3)

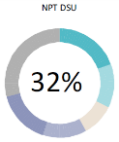
- No Personal Injury claims
- No Never Events
- No Clinical Negligence claims

Incidents:

340 incidents were reported with the top themes being:

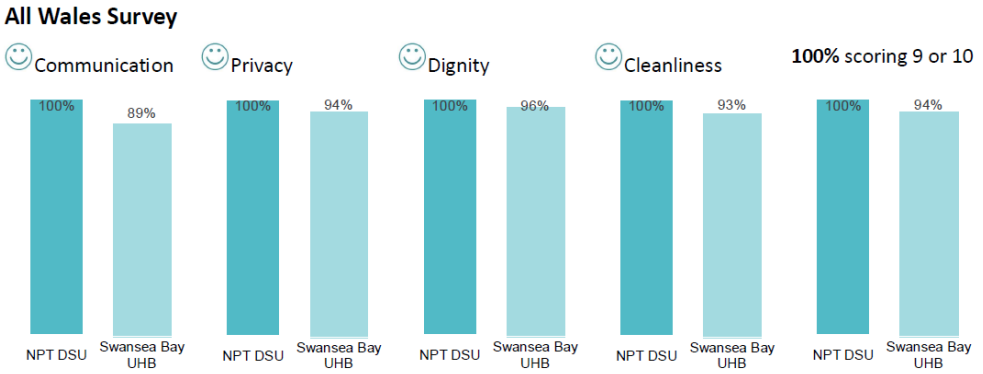
- Suspected Slips/Trips/Falls (un-witnessed) – (22)
- Inappropriate behaviour towards staff by patient – (13)
- Suspected Slips/Trips/Falls (witnessed) – (8)

No Serious Incidents were reported during February 2021



Friends & Family Results – February 2021

of the 31 respondents, 10 said that overall their experience of the service was good or very good.

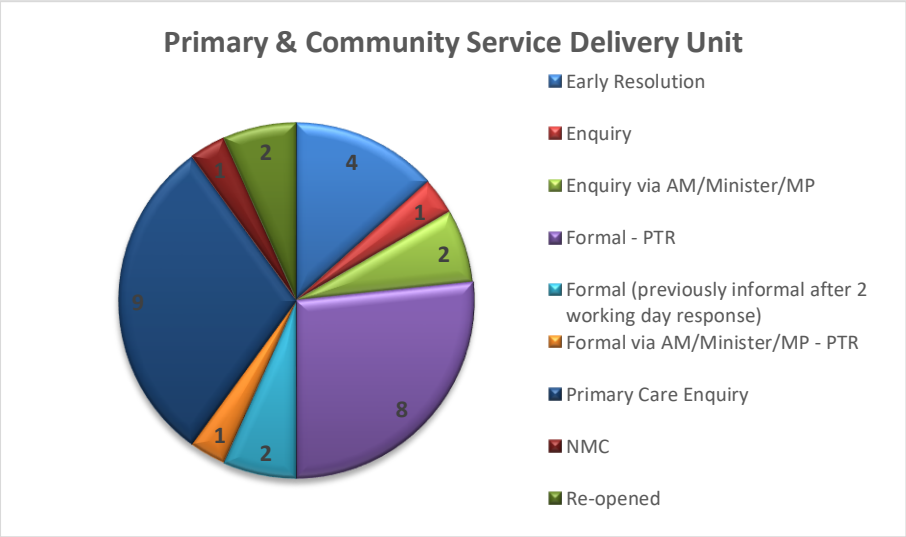


1 All Wales Surveys were received for the Service Delivery Unit during February 2021 with the overall score of 100%.

Primary & Community Service Group

1st February– 28th February 2021

Primary & Community SG received 29 concerns.



Top Complaint Trends

- Communication (9)
- Clinical Treatment (6)
- Appointments (4)

- No Personal Injury claims
- No Never Events

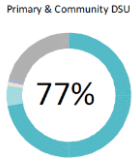
- 2 Clinical Negligence Claims

Incidents:

340 incidents were reported with the 3 top themes being:

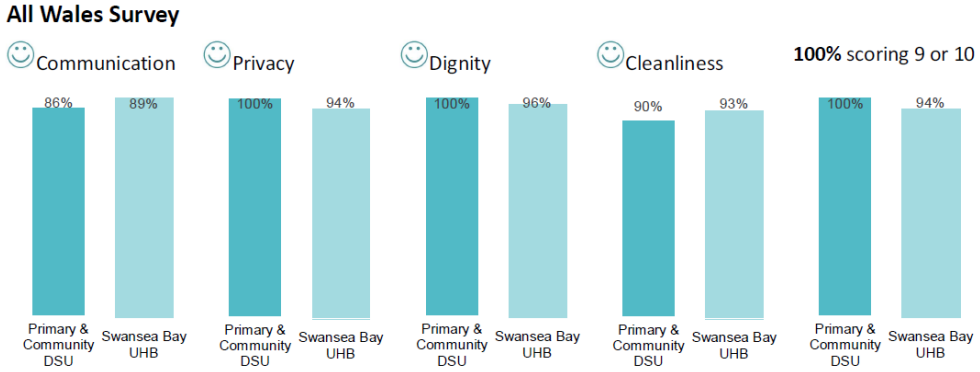
- Pressure Ulcer – developed prior to admission (128)
- Moisture Lesion- (85)
- Injury of unknown origin (32)

Two Serious Incidents were reported during February 2021 both relating to Pressure Ulcers



Friends & Family Results – February 2021

of 97 respondents, 75 said that overall their experience of the service was good or very good.

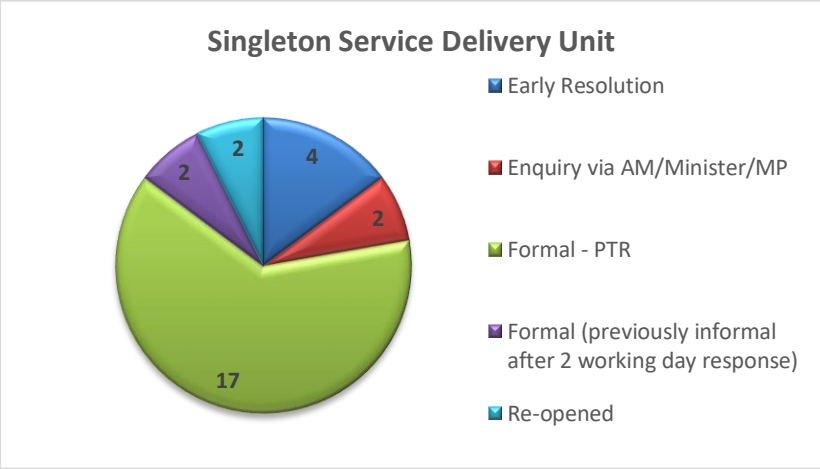


10 All Wales Surveys were received for the Service Delivery Unit during February 2021 with the overall score of 100%.

Singleton Hospital Service Group

1st February- 28th February 2021

Singleton Hospital SG received 27 concerns.



Top Complaint Trends

- Communication (8)
- Clinical Treatment (6)

- 0 Personal Injury Claims
- 0 Never Events

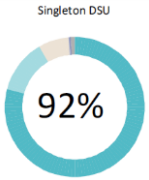
- 2 Clinical Negligence claims

Incidents

384 incidents were reported with the 3 top themes being:

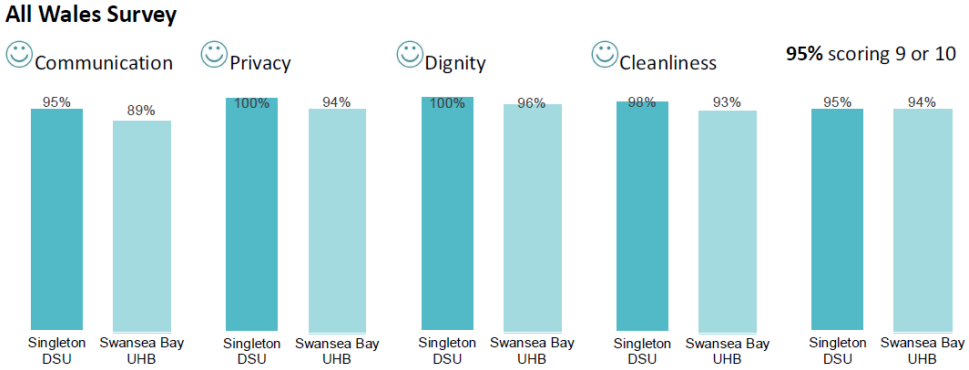
- Maternity Triggers – (38)
- Moisture Lesion (37)
- Suspected Slips, Trips, Falls (unwitnessed)– (32)

1Serious Incident was reported during February 2021 relating to a Neonatal Care



Friends & Family Results – February 2021

of 459 respondents, 420 said that overall their experience of the service was good or very good.



63 All Wales Surveys were received for the Service Group during February 2021 with the overall score of 95%.