



# **Patient Experience, Risk & Legal Services Report October 2020**

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 Delivery Units 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 23<sup>rd</sup> March until the Covid situation improves.

We did begin reintroducing the manual collection of the Friends and Family from 1<sup>st</sup> September. However, the service was suspended 2 weeks later due to the increase of the Covid cases across the hospitals. We will continue to review the situation.

- **Developed an electronic survey** which is available online and also sent out weekly via SMS messages to discharged patients across the Health Board. The survey focusses on communication, virtual visiting/appointments and the availability of clothing and toiletries.

The Covid-19 survey results are being shared with the Health Boards DSUs. The results are also shared with Person Centred Care Cancer Steering Group, Eye Care Collaborative Group.

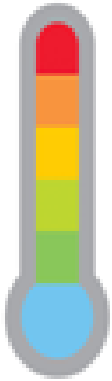
- For the month of October there were 1,047 Friends and Family online survey returns which resulted in 82% of people stating they would highly recommend the Health Board to Friends and Family which was a 11% decrease from September 2020.
- The 11% decrease was due to a drop in the Singleton DSU recommendation score compared to September. September recommendation score: 96% and October recommendation score: 88%. The reasons for this are there was a significant drop in responses from September in Singleton (September responses: 1,824 and October responses: 530). The reason for the decrease in responses include:
  - Blood tests service being down.
  - The Antibody testing service brought in 1125 responses in September, however, there were only 75 in October.
  - the Breast Care Unit in Singleton having a recommendation score of 9%. There were 11 responses of which 45% rated the service as poor. There was one 'good' response, four 'poor' and one 'very poor'. There were then five responses for 'neither'. By selecting neither, this brings the score down. The PALS Team in Singleton have been notified of these responses.

From the 1,047 responses received the high response areas across the reporting period (all with 100% positive feedback) included:

- Ward 02 (Surgery) - Morriston Hospital (32 responses)
- Ward 09 (Cardiac) - Morriston Hospital (28 responses)
- Physiotherapy Outpatients Dept – Neath Port Talbot Hospital (10 responses)
- Intensive Therapy Unit – Morriston Hospital (16 responses)
- Antenatal Clinic – Neath Port Talbot Hospital (8 responses)
- AMAU East – Morriston Hospital (7 responses)
- Antenatal Clinic - Neath Port Talbot Hospital (8 responses)

- Ward G (Surgery) - Morriston Hospital (7 responses)
- Ward C (Cardiac) – Morriston Hospital (6 responses)
- Ward V (Surgery) - Morriston Hospital (6 responses)

The 10 lowest scoring (Below 90%) areas for the reporting period (1<sup>st</sup> October to 31<sup>st</sup> October 2020) were:



- Ward E – Neath Port Talbot Hospital (67%) (5 responses)
- Cardigan Ward – Morriston Hospital (63%) (35 responses)
- Anglesey Ward - Morriston Hospital (57%) (21 responses)
- Cardiac Rehabilitation – Morriston Hospital (55%) (11 responses)
- Cardiac Short Stay Unit– Morriston Hospital (50%) (8 responses)
- Haematology Day Unit – Singleton Hospital (43%) (7 responses)
- Audiology Unit – Neath Port Talbot Hospital (33%) (3 responses)
- West Ward – Gorseinon Hospital (25%) (16 responses)
- Children’s Centre – Neath Port Talbot Hospital (20%) (5 responses)
- Outpatients Department - Gorseinon Hospital (8%) (26 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.

We have investigated the reason for the department’s low scores. The reason why the scores are so low is because a lot of people are selecting ‘neither’ or ‘don’t know’ on the ‘Overall, how was your experience of our service?’ question. The negative comments which were left related to:

#### **West Ward, Gorseinon Hospital:**

Very poor receptionists most days.

Make sure everybody gets their Antibody test results back.

More nurses, less ‘helpers’.

#### **Haematology Day Unit, Singleton Hospital**

Better Wi-Fi connection (this was mentioned multiple times). IT have been notified of these issues.

#### **Cardigan Ward, Morriston Hospital**

Management of difficult patients. Had one patient constantly screaming and demanding attention from the already understaffed and overworked nurses. For the entire 2 weeks I was here, they didn't let up and some nurses and us patients were in tears of frustration not knowing what to do. The PALS Team have notified of this issue.

## 1.2 Patient Experience Team Work

- **Patient Stories:** To strengthen the message to staff regarding Social Distance and the use of Personal Protective Equipment messages across the organisation, a patient story was developed to support the delivery of the message called 'William's Story'. This story was played at Covid-19 Gold Command meeting and shared across the organisation. There is also a request from Welsh Government to also use the story during their meetings.

We have also introduced a Swansea Bay Story bulletin, which is sent to members on the SharePoint to keep them updated with new stories which they can use.

Welsh Government have asked us to lead the discussion on an All Wales Digital Story Platform. The Health Board have already developed a process, training, toolkit and guides. The aim being to 'lift & shift' the process across Wales with local amendments. Welsh Government are working with NWIS on a National platform to support the stories. The stories and learning will be shared across the NHS in Wales to promoting learning.

- **Patient Cancer Centred Care:** We are working with the team to share the cancer feedback we have recently received. We have also agreed to attend the Cancer Improvement Board and support their capture of patient feedback and stories.
- **Social Media – Laundry to loved ones:** Working with Unit Governance managers we developed a social media message regarding laundry to loved ones during the local and national lockdown.
- **Supporting Emergency Roche helpline:** Staff from the Patient Experience team supported the emergency telephone calls from members of the public over a two-week period.
- **Mental Health & Learning Disabilities:** We continue to pilot the new questions with the team, discussions are ongoing regarding the reporting template. To date we have had 15 completed surveys.
- **Welsh Language Feedback:** Supported the Welsh Language team providing survey results regarding patient's use of Welsh language while in our care for the last 3 years. This data is being used in their Framework report.
- **Continence Service Group:** Met with the team to discuss how we can capture online feedback via virtual appointments. We highlighted how other clinics were able to capture feedback and signposted to the 'leader in this field'.
- **Attend Anywhere (virtual appointment platform) staff survey:** We worked with the senior project manager to develop a staff survey to capture staff experience/feedback when using the

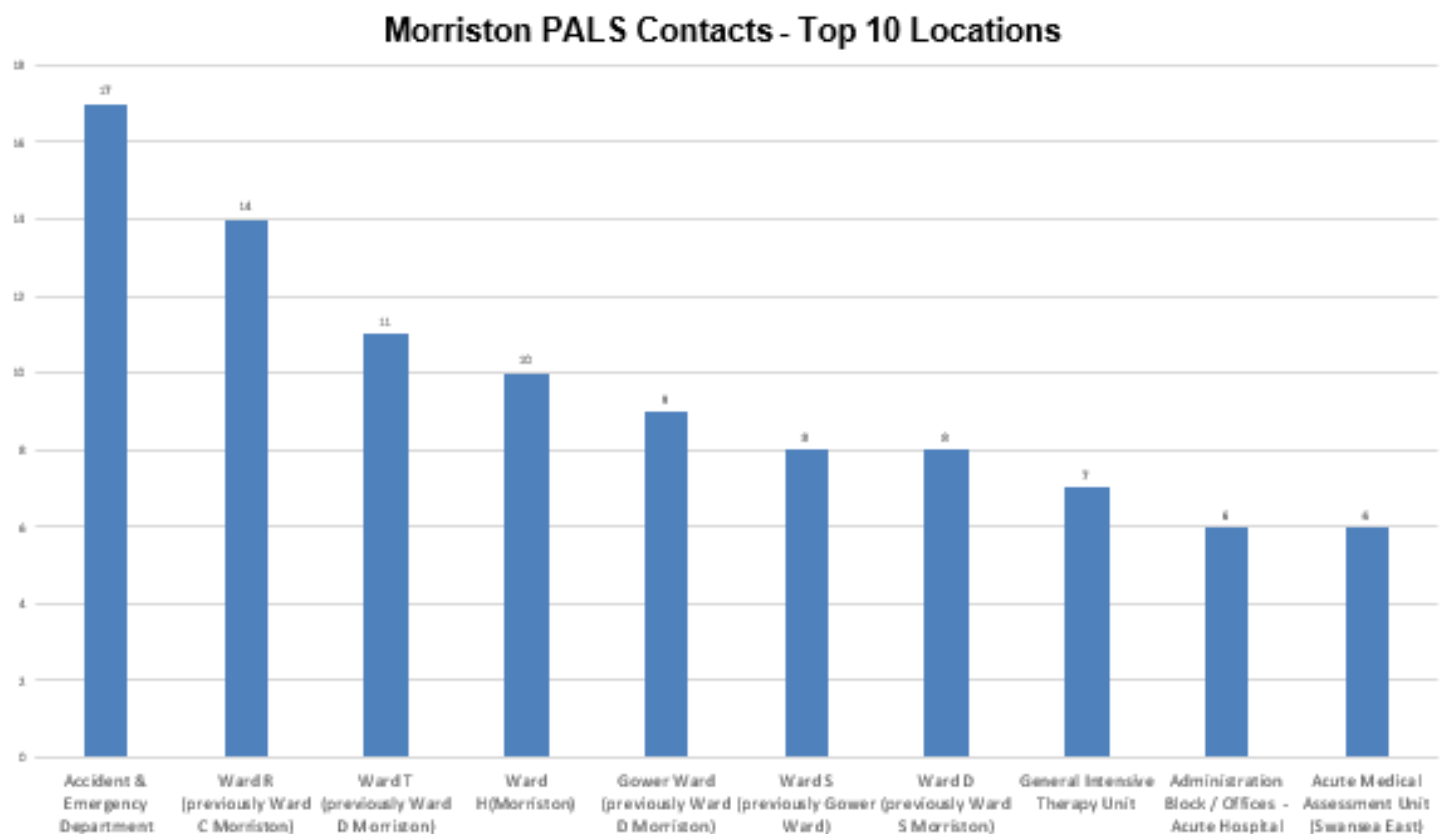
virtual clinic platform. The survey is now closed and there have been 216 complete surveys. The Senior project team will use the summary survey report to shape and direct improvements to the platform. This feedback will be used nationally in evaluating the system, and highlight areas for improvement.

- **All Wales Listening and Learning Framework:** We have been involved with the All Wales project for revising the Listening and Learning Framework. We have worked with other Patient Experience leads and developed a toolkit. We are also looking at the core questions and reviewing if there should be themes rather than core questions. This work is ongoing and will be supported by the Welsh Government.

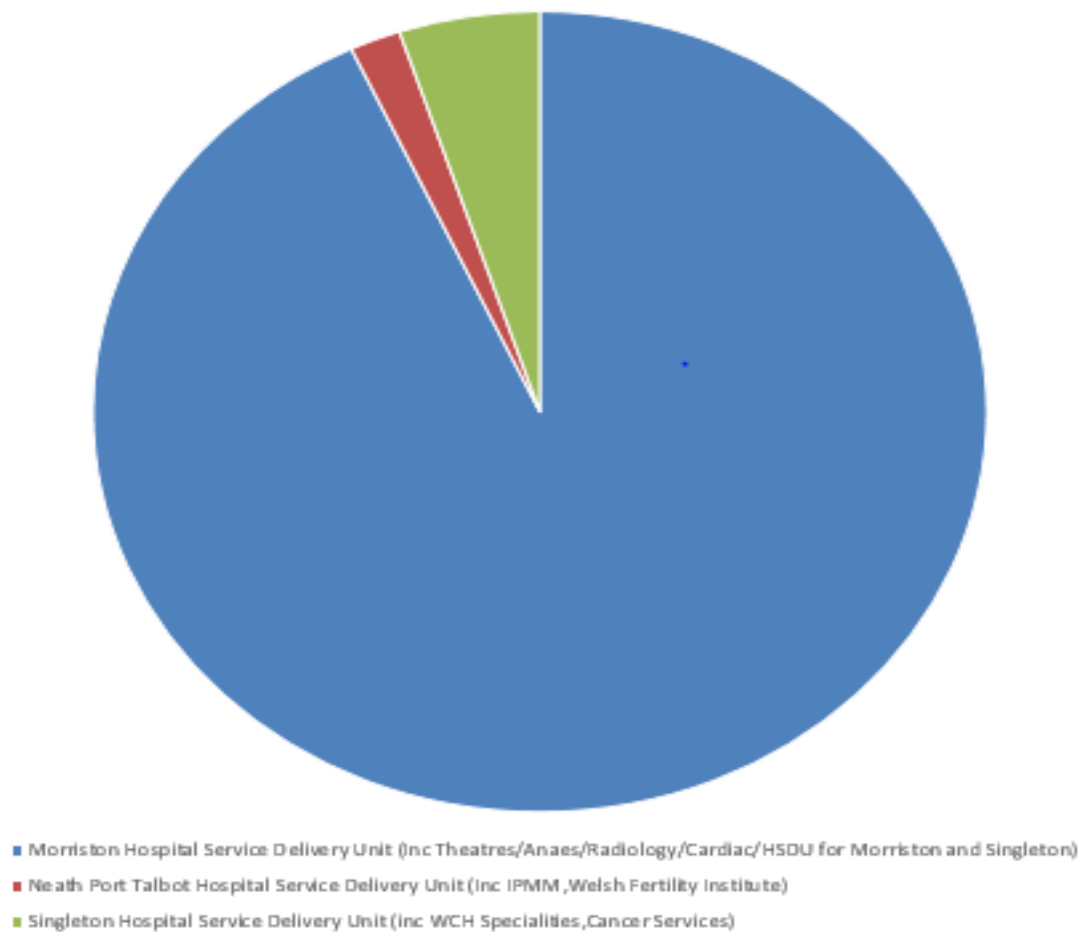
### **1.3 Patient Advisory Liaison Service (PALS) Activity – October 2020**

During the month of October 2020, the Health Board's PALS Teams recorded 649 records on the Datix system, this compared to a total of 184 contacts for October 2019.

These are broken down by each PALS Team/Delivery Unit below, Morriston having the highest number with 604 contacts.



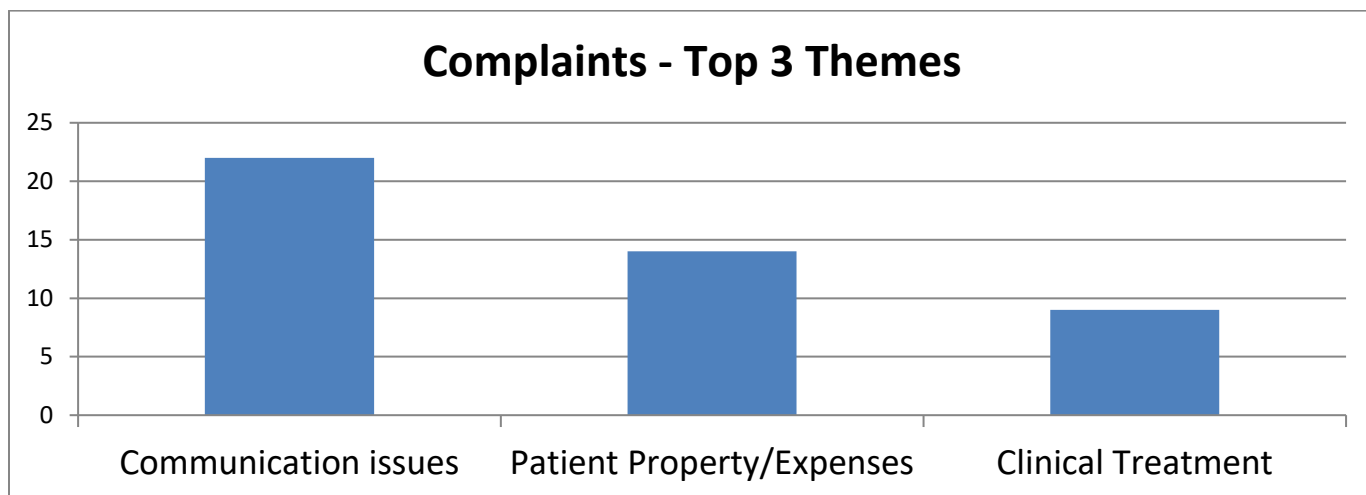
**PALS Contacts by Units**



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

<b>Advice</b>	4
<b>Bereavement</b>	19
<b>Comment</b>	26
<b>Compliment</b>	8
<b>Concern</b>	84
<b>Help</b>	56
<b>Information</b>	15
<b>Support</b>	437

Out of the 84 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.

A bulletin placed on the staff intranet September, it has been very successful and a number of contacts from across the Health Board have been in touch to arrange communication training.

Training can be provided where necessary one to one, in pairs, or Groups up to eight. To access this provision or to make enquiries Kathryn can be contacted on 07903672208 or [Kathryn.ratcliffe@Wales.nhs.uk](mailto:Kathryn.ratcliffe@Wales.nhs.uk).

## 1.4 All Wales Patient Experience Questionnaire - 29 returns

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


### Key Determinants of a Good Service User Experience

The key determinants of a good service user experience, based on national and local published evidence, include:

#### First and Lasting Impressions

For example:

- Being welcomed in an appropriate manner;
- Being able to access services in a timely way;
- Being treated with dignity and respect.



#### Receiving care in a Safe, Supportive, Healing Environment

For example:

- Receiving care in a clean, clutter free environment;
- Receiving good, nutritious, appropriate food;
- Having access to drinks;
- Having rigorous infection control practices in place.



#### Understanding of and Involvement in Care

For example:

- Receiving appropriate, timely information;
- Being communicated with in an appropriate, timely manner;
- Involvement of patients, carers and families in decisions about choice of treatment options and care plans, including discharge and transfer.



These three domains can be used to support the use and design of feedback methods and be used to classify feedback from all sources.

## Reduced numbers of returns due to Covid

Percentage of patients that ticked 'Always' to the following questions:											
Treated with Dignity?											
Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
97%	95%	95%	92%	97%	100%	100%	92%	92%	93%	88%	96%
You were given help with feeding and drinking											
Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
70%	50%	93%	87%	0%	100%	0%	0%	80%	40%	76%	75%
Were you given the support you needed to help with any communication needs?											
Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
93%	95%	92%	92%	98%	100%	93%	82%	87%	89%	83%	90%
Were things explained to you in a way that you could understand?											
Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
90%	90%	90%	86%	93%	95%	100%	92%	94%	87%	76%	89%
Did you feel we did enough to keep you as free as possible from pain?											
Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
87%	81%	91%	86%	75%	100%	100%	67%	89%	79%	85%	81%
People are kind and compassionate to you?											
Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
91%	88%	90%	91%	92%	100%	100%	78%	92%	96%	81%	91%
People are welcoming, friendly and helpful?											
Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
89%	88%	92%	95%	88%	100%	100%	67%	90%	91%	83%	96%
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?											
Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
86%	83%	85%	86%	88%	100%	80%	67%	86%	83%	84%	71%



## 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’ – September 2020

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 the month of September, there were 53 contacts. 11 were converted to complaints; 1 compliment and 1 transferred to Cwm Taf University Health Board. The remaining related to queries which PALS managed and marketing emails/ accidental pocket calls.

**‘Social Media’**- 6 Social Media – 2 for Paeds, 1 Minor Injuries Neath Port Talbot, 1 A&E, 1 Deep South team/ITU, 1 Morriston.

### ‘Let’s Talk’ – October 2020

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 the month of October, there were 44 contacts. 9 were converted to complaints; 2 compliments and 0 transferred to Cwm Taf University Health Board. The remaining related to queries which PALS managed, GP correspondence and marketing emails/ accidental pocket calls.

**‘Social Media’**- 1 social media – Morriston Ward M



No contacts for October.

## I Want Great Care

We received three positive reviews for Singleton Hospital through the I Want Great Care website for the month of October. There were no comments left but they gave five star reviews for the following options: Recommendation, Dignity/Respect, Involvement, Information, Cleanliness and Staff. These reviews were left by a carer, however, they did not specify the area.

Obtaining info re action/response from the Service Group.

### 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.

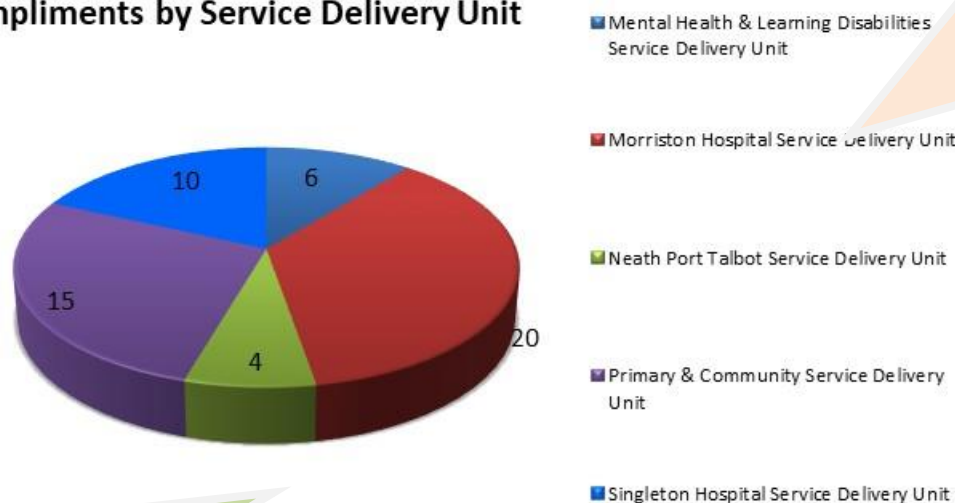
The NHS Delivery Unit issues the first leaning brief nationally from NHS organisations reporting learning from Covid-19 cases: **CoRSEL learning update #1** To all HBs/Trusts. The update provided a summary of **early learning** related to in-hospital transmission of Covid-19. The learning brief has been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

### 3. COMPLIMENTS

A total of 55 compliments were recorded on Datix between 1<sup>st</sup> October 2020 and 31<sup>st</sup> October 2020, a breakdown by the Delivery Units is provided on Page 14 and a selection of compliments received.

### 3.2 Written Compliments – October 2020

#### Compliments by Service Delivery Unit



*"Invaluable direct link for people with learning disabilities. Extensive knowledge and history of learning disabilities. Providing nursing support and adapted processes in the supporting of timely care. Ability to streamline communication around updated information relating to persons with a learning disability."*

**Compliment regarding an Acute Learning Disability Liaison Nurse  
Mental Health and Learning Disabilities Delivery Unit**

*"I write to you to not only highlight the professionalism and kindness shown to me by my Health Visitor but also the importance of such a worker and team, without whom I would have certainly have given up breastfeeding, or if I did not, would no doubt have continued to suffer with mastitis, expending more time and resources from teams such as the breast clinic and my GP who are already overstretched".* **Community Health Visiting Team, Norton Clinic**

*"I found all the staff, from Porters to Consultants, very friendly. Especially the student nurses who always had time to have a chat when taking your obs during the day. In the current climate where visitors were not allowed this made an intolerable situation much more bearable."*

*Can you please pass on my thanks to all the staff who took such good care of me."*

**Morrison Hospital, Cyril Evans Ward**

*"I have to express my praise to the team at Singleton Hospital's Diabetic Unit, specifically the diabetes nurses. I have been recently diagnosed with Type 1 Diabetes, and whilst it was a massive shock I honestly can't express how amazing these 2 have been. From explaining everything to me, to ringing me just to see how I'm getting on. There's support system is second to none and has honestly made what some would see as a bad experience, a really pleasant one. So if you are able to pass my gratitude on to whomever oversees them and know you have a fantastic team at Singleton Hospital".* **Diabetology Department, Singleton Hospital**

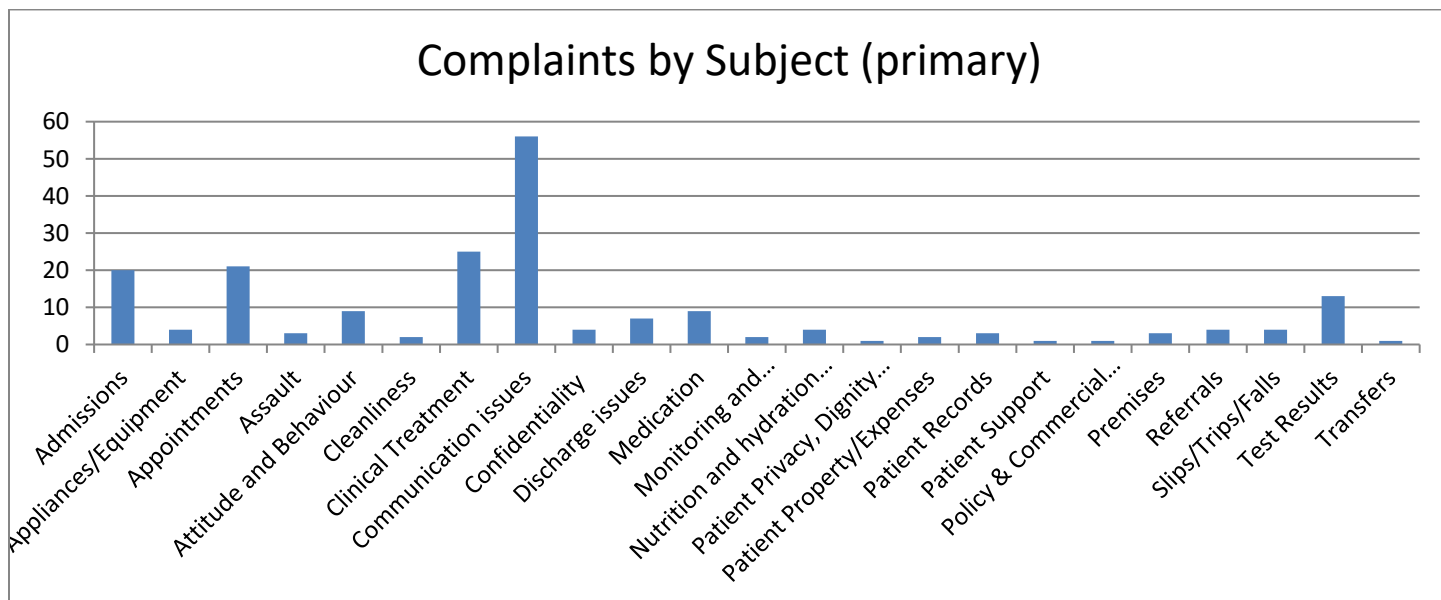
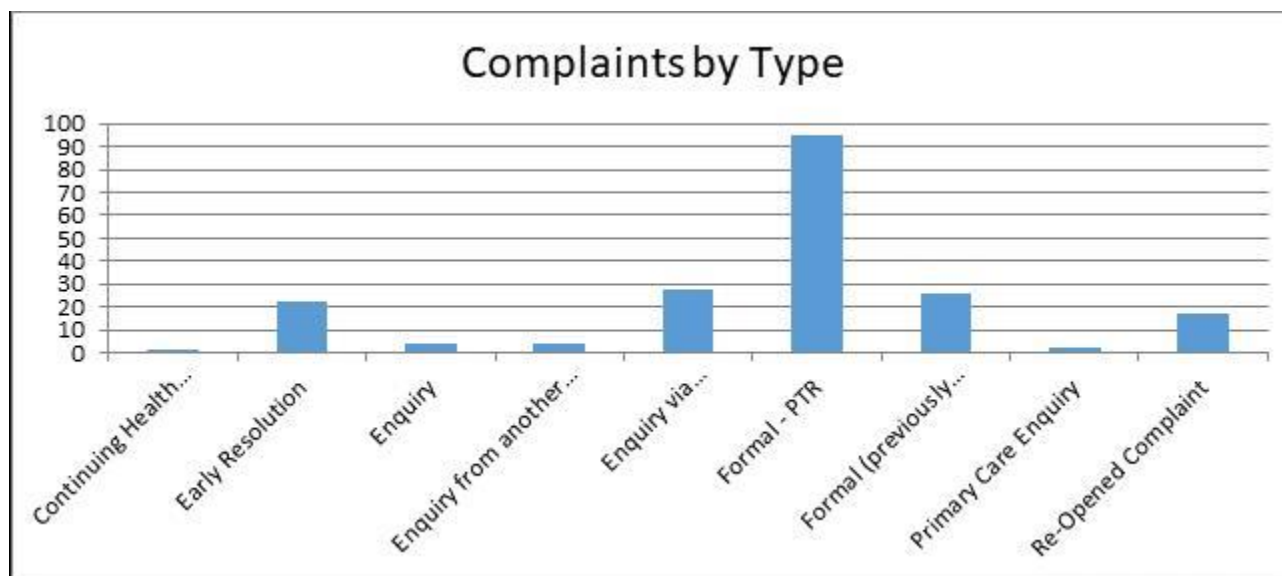
*"I would like to inform you of the wonderful service which my son received yesterday evening in NPT and Morrison hospitals. He fell and sustained a fracture to his elbow. We were seen very promptly in minor injuries in NPT and received difficult information that surgery was required to repair the bone in a sensitive and delicate manner. I would like to express my thanks for the whole treatment process yesterday evening, my son was very fortunate to be able to receive such good care".* **NPT MIU & Morrison Orthopaedics**

## 4. CONCERNS MANAGEMENT

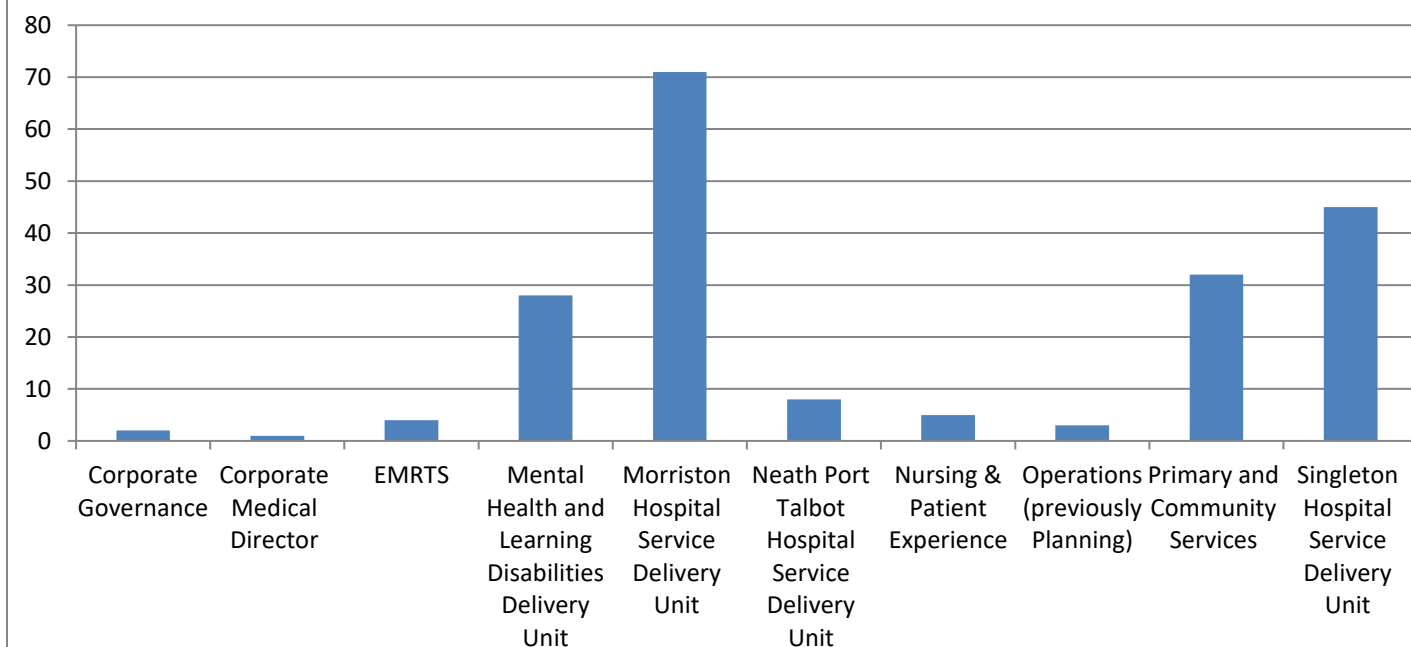
### 4.1 Complaints – October 2020

#### Complaints 1.10.20 – 31.10.20

The Health Board received 199 complaints during the month October 2020, please see breakdown by subject and unit below;



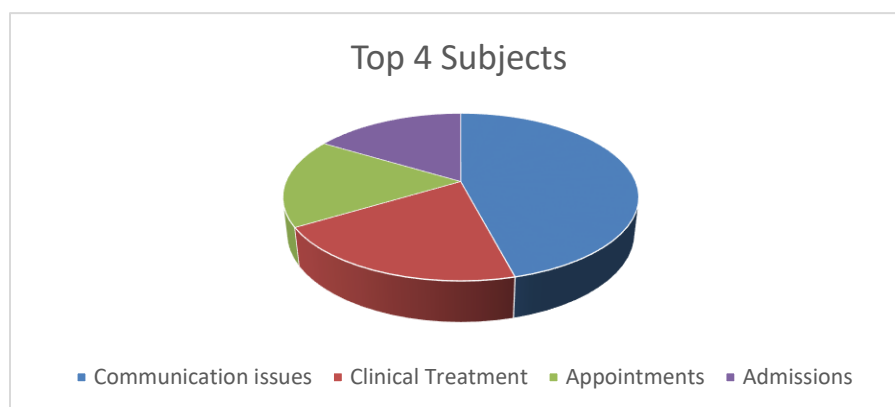
## Complaints by Delivery Unit/Directorate



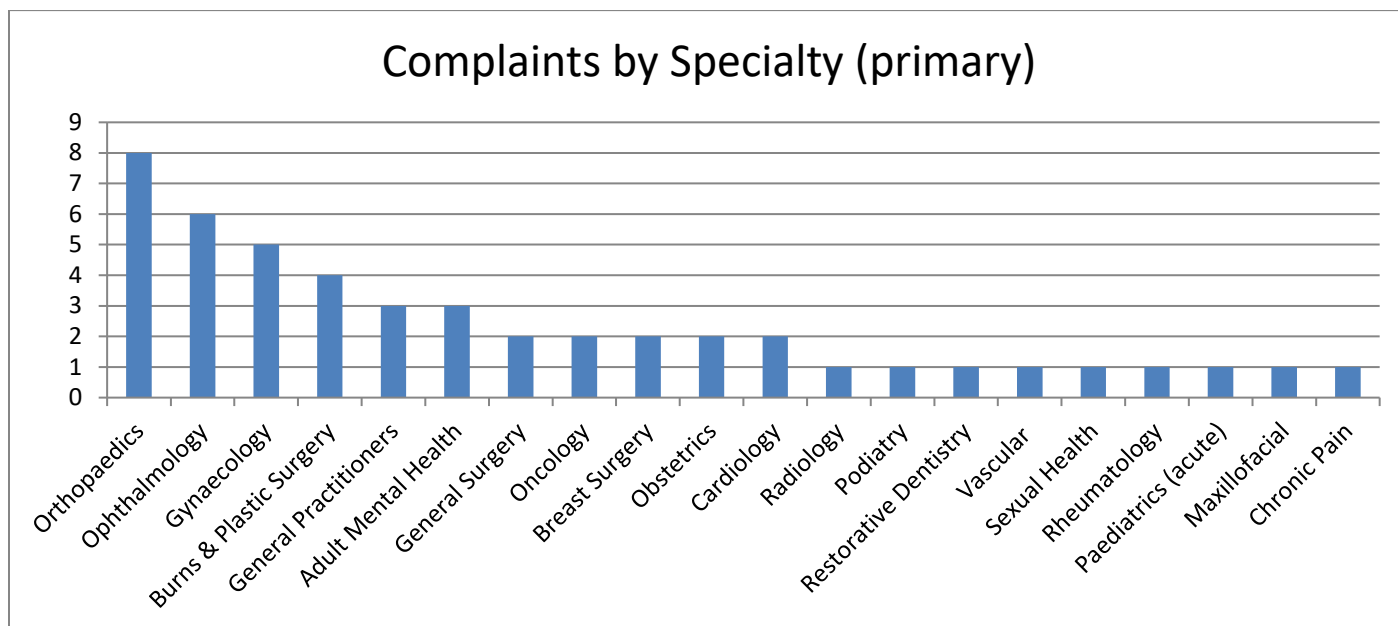
Out of these 199 complaints, 11 related to COVID-19, please see subject breakdown below;

<b>Aggressive/Inappropriate behaviour due to restrictions</b>	<b>1</b>
<b>Lack of communication</b>	<b>1</b>
<b>Contact with Patient/Staff with suspected COVID-19</b>	<b>1</b>
<b>Acquired COVID-19 during admission</b>	<b>1</b>
<b>Cancellation of treatment/appointment/Clinic due to COVID-19</b>	<b>1</b>
<b>Infection Control (contamination)</b>	<b>1</b>
<b>Delay in Diagnosis/Testing for COVID-19</b>	<b>1</b>
<b>Room/location unable to be used/unavailable</b>	<b>3</b>
<b>Access to other treatment</b>	<b>1</b>

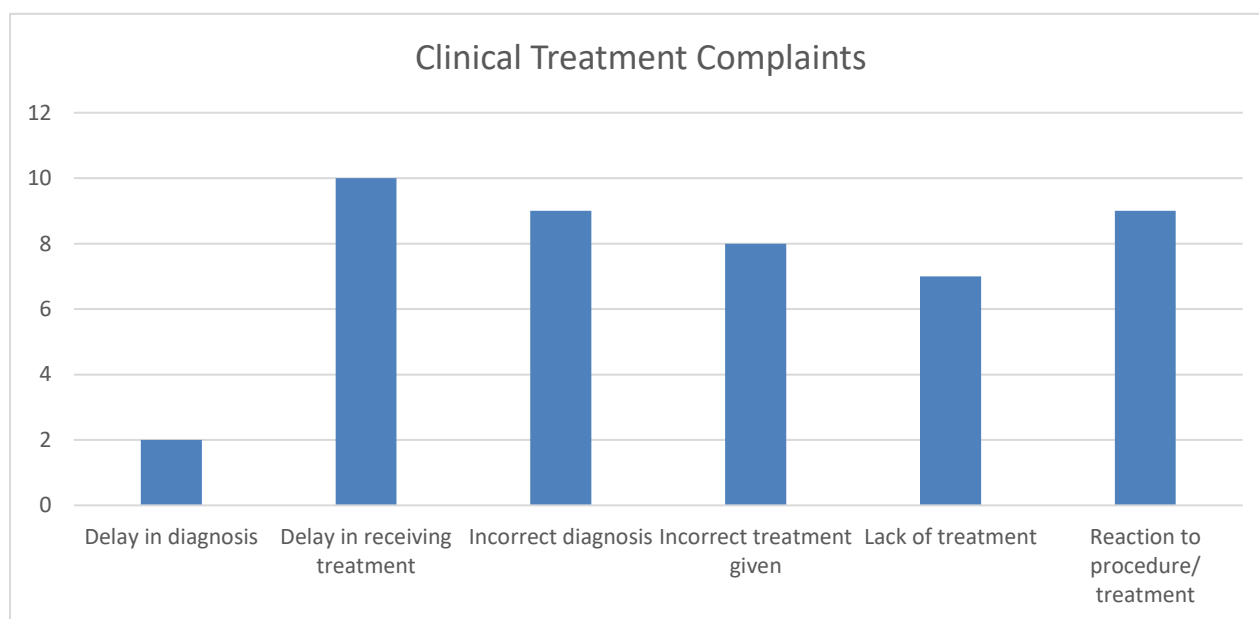
### Top 4 Complaint Themes



During October there were 48 complaints received which related to cancelled or delayed appointments or admissions. Please see breakdown by specialty below;



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



## 4.2 Concerns Assurance

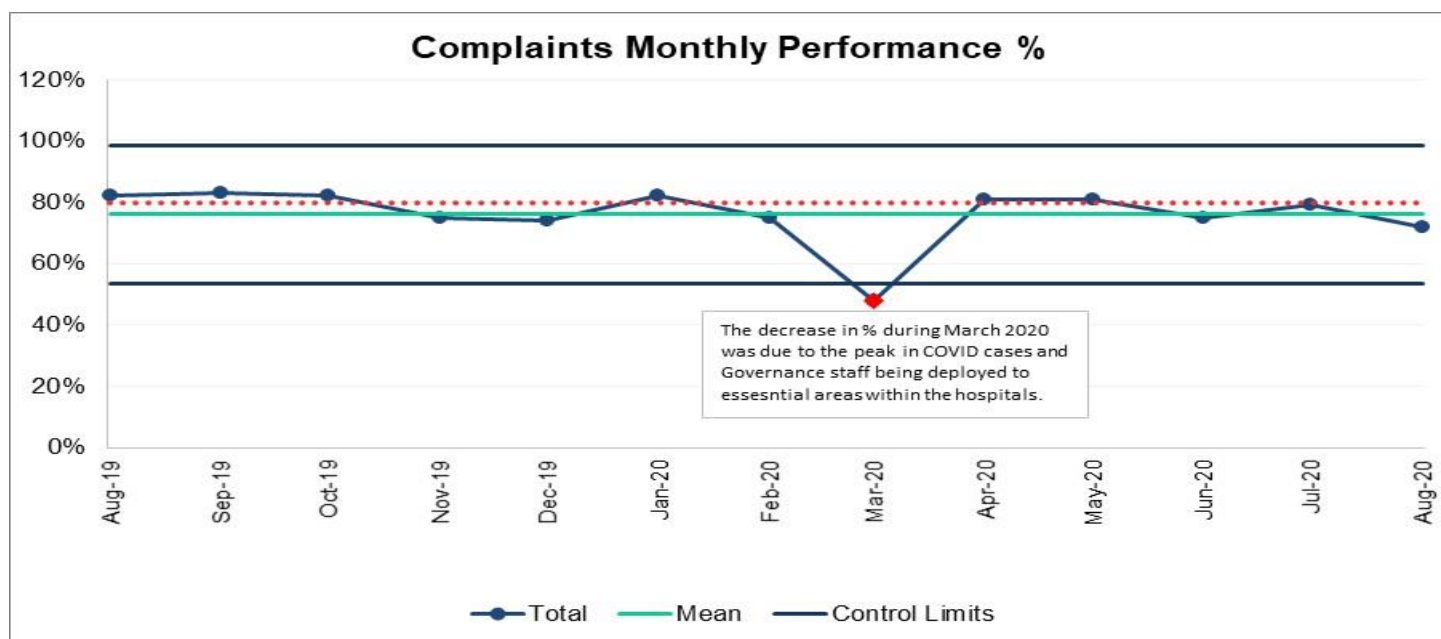
On a monthly basis, the Health Board conducts a Concerns Redress Assurance Group (CRAG) where the Corporate Complaints Team review recently closed complaints. A 'deep dive' review is undertaken on each Service Groups in turn, as well as the review of a selection of closed complaints from the other Service 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. The Health Board has also introduced CRAG workshops where learning is shared with senior members of the Service Delivery Units.

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.

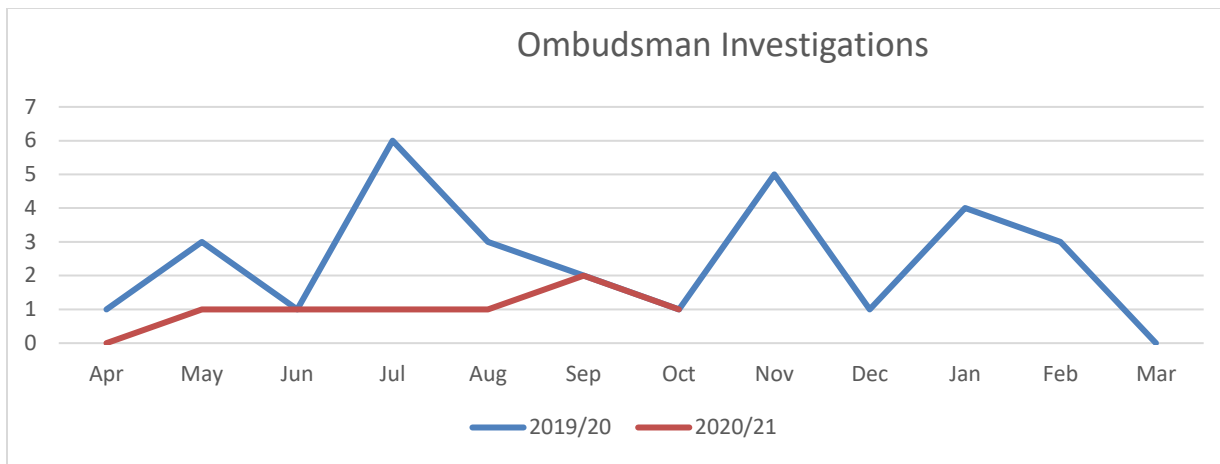
#### 4.3 Complaints Performance

The Health Board recorded 72% performance against the 30 working day target in August 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 was one new investigation received during October 2020.



The Ombudsman has confirmed that there has been a decrease of complaints investigated by the Public Services Ombudsman for 2019/20 compared to 2018/19. The Patient Feedback Team remains committed to improving this trend. All cases that have been referred to the Ombudsman's Office are reviewed to ensure learning and improvement. The Patient Feedback Team has ensured that all Ombudsman timescales are met to ensure continued timeliness when communicating with the Ombudsman. The Health Board has Ombudsman Key Performance Indicators in place, which are monitored on the Datix system, assist with achieving the timescales set by the Ombudsman.

An Ombudsman Project Plan has been implemented, and a tailored training programme providing Ombudsman Learning and Assurance training has been delivered to each Unit Governance Team, based on identified themes and trends. The training incorporated the importance of complying with actions agreed at meetings with complainants and in complaint responses. This will ensure a robust system is in place in the Service Delivery Units.

#### 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 2020. These meetings are currently being undertaken and attended remotely.
- Tailored Mental Health & Learning Disabilities training is currently being arranged to reinforce the Regulations and Redress process.
- Two Complaints Newsletters have been issued, which include learning from Ombudsman cases, PALS work and management of complaints.
- Work with Ombudsman Office due to commence to introduce Complaints Standards Training.
- Ombudsman Complaints Standards Training due to commence in March/April 2020.



## 4.5 Incidents

### 4.5.1 Incident Reporting & Performance

For the period 1<sup>st</sup> October 2020 to 31<sup>st</sup> October 2020 a total of 1,845 incidents were reported (September was 1,739). The severity of the level of harm of incidents reported is set out as follows:

Severity of Harm	Incidents Reported
No Harm (1)	1363
Low (2)	338
Moderate (3)	126
Severe (4)	6
Death (5)	12
<b>Total</b>	<b>1845</b>

The top five themes relate to:

Incident Type Tier One - Top 5	No	
Injury of unknown origin	292	15.82%
Patient Accidents/Falls	214	11.59%
Pressure Ulcers	189	10.24%
Behaviour (Including Violence and Aggression)	146	7.91%
Behaviour	111	6.01%

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 292 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
Injury of unknown origin	80
Non SBUHB acquired Moisture lesion	130
SBUHB acquired Moisture lesion	82
<b>Total</b>	<b>292</b>

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

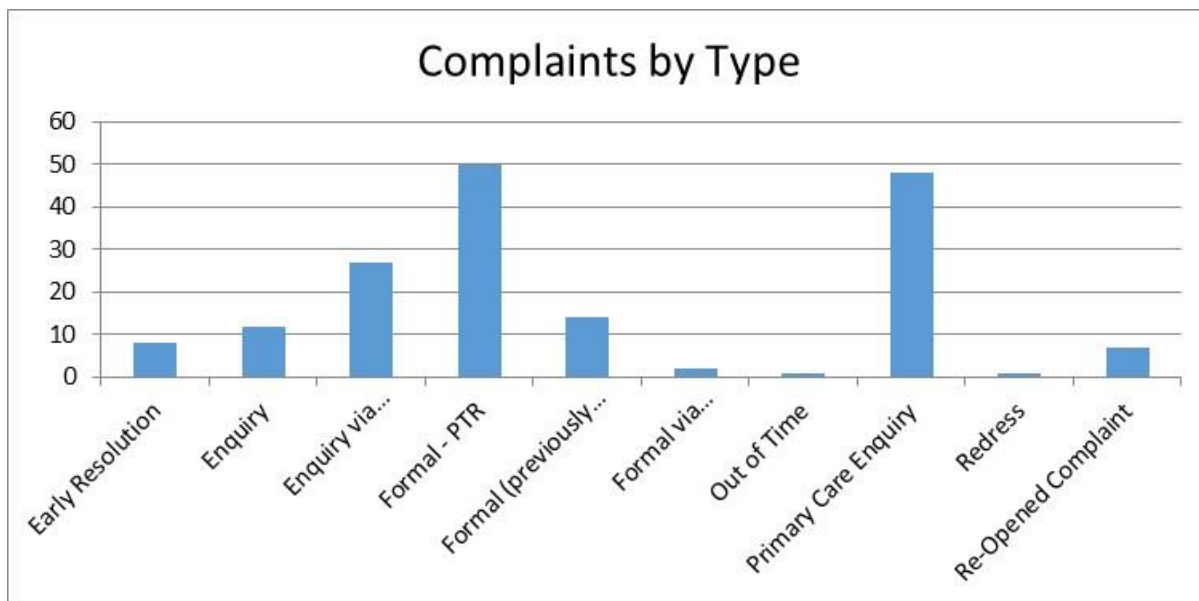
Scrutiny of these cases identified 14 incidents which had been incorrectly coded. These cases have now been updated and coded correctly as follows:

Pressure Ulcer	9
Moisture Lesion	2
Behaviour	1
Equipment	1
Accident	1

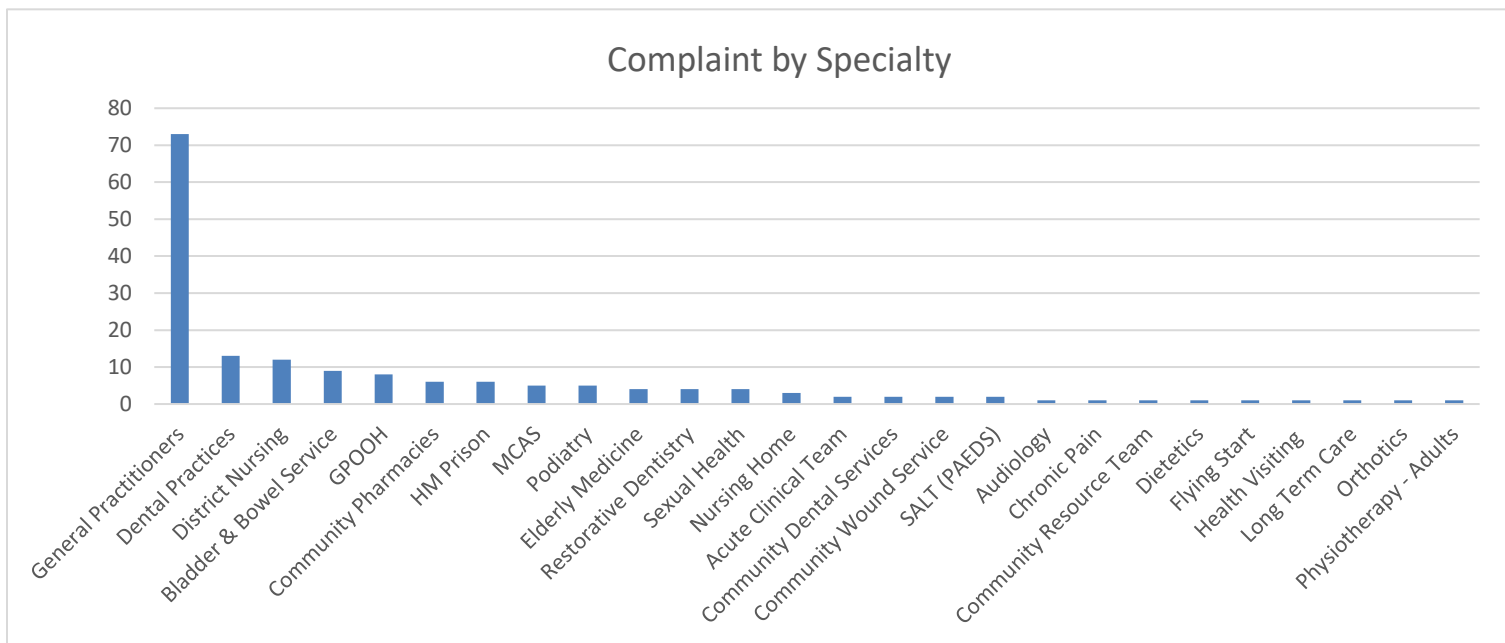
Consideration is being given to how health organisations in Wales classify these incidents to ensure consistency as part of the Once for Wales Work.

### **Primary & Community SDU Complaints**

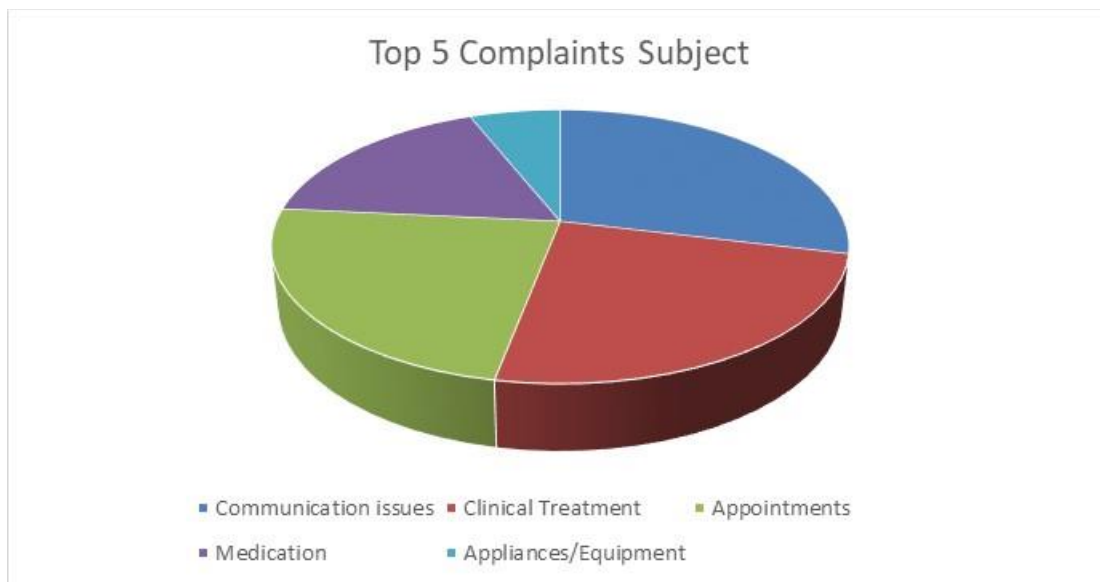
The Primary & Community Delivery Unit received 170 complaints between 1.4.20-30.9.20. 48 of these have been logged as 'Primary Care Enquiry' and would have been referred back to the practitioner to respond. Please see breakdown below:



Also below is a breakdown of all Primary & Community complaints by Specialty as you will see the highest area is GP's, as explained above, the majority of these would have been referred to the practices to respond:



The top 5 complaint themes are below with the highest being communication;



Each top theme has been broken down further below;

Communication Issues	
Insufficient information	20
Unable to contact	10
Incorrect information	8
Lack of feedback/referral/discharge summary	2
Patient involvement in care decisions	1

Clinical Treatment Issues	
Lack of treatment	11
Delay in receiving treatment	10
Delay in diagnosis	9
Incorrect diagnosis	8
Incorrect treatment given	4
Reaction to procedure/ treatment	2

Appointments	
Delay in receiving outpatient appointment	12
Delay in appointment	11
Appointment cancelled	4
Patient booked into wrong outpatient clinic	2
Capacity of clinics	1
Continuity of staff	1

Medication Issues	
Availability of medication	6
Incorrect dosage given	5
Failure to provide medication	3
Incorrect medication given	3
Medication not prescribed	3
Delay in medication	2
Frequency of providing medication	1
Prescription incorrect	1

Appliances/Equipment	
Lack of equipment	4
Availability of equipment	2
Delay in obtaining equipment	2
Unfit for purpose	1

Out of the total complaints, there were 52 formals including 7 amber complaints.

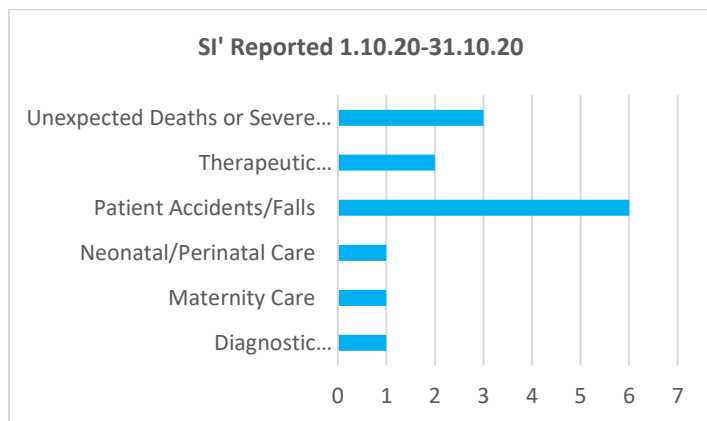
#### **4.5.2 SI's Reported 1<sup>st</sup> October 2020 to 31<sup>st</sup> October 2020**

During the pandemic, Welsh Government changed the SI reporting criteria, reported to the Q&SGG in March 2020, however, this has now reverted back to the criteria that was in place prior to COVID.

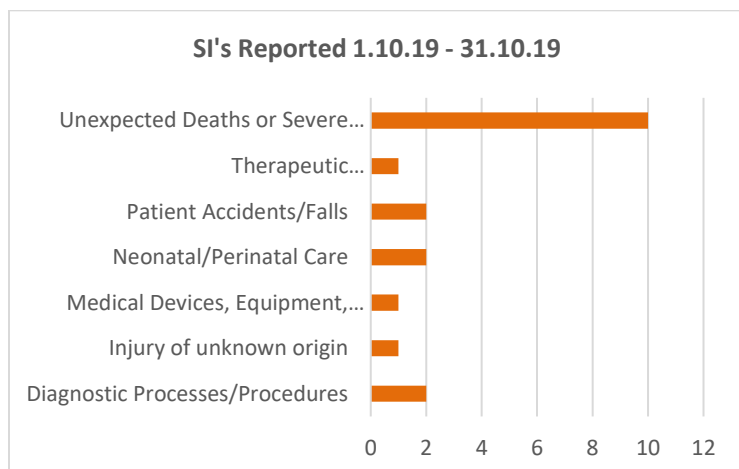
**From 1<sup>st</sup> October 2020** all SI's will be reported to the NHS Delivery Unit who have taken over responsibility for reviewing new SI's and assuring the closure forms. No Surprise Reports will still be reported to Welsh Government. From a Health Board perspective, the Serious Incident Team have reviewing 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 October 2020 a total of 14 serious incidents were reported to Welsh Government of which 3 related to unexpected deaths.

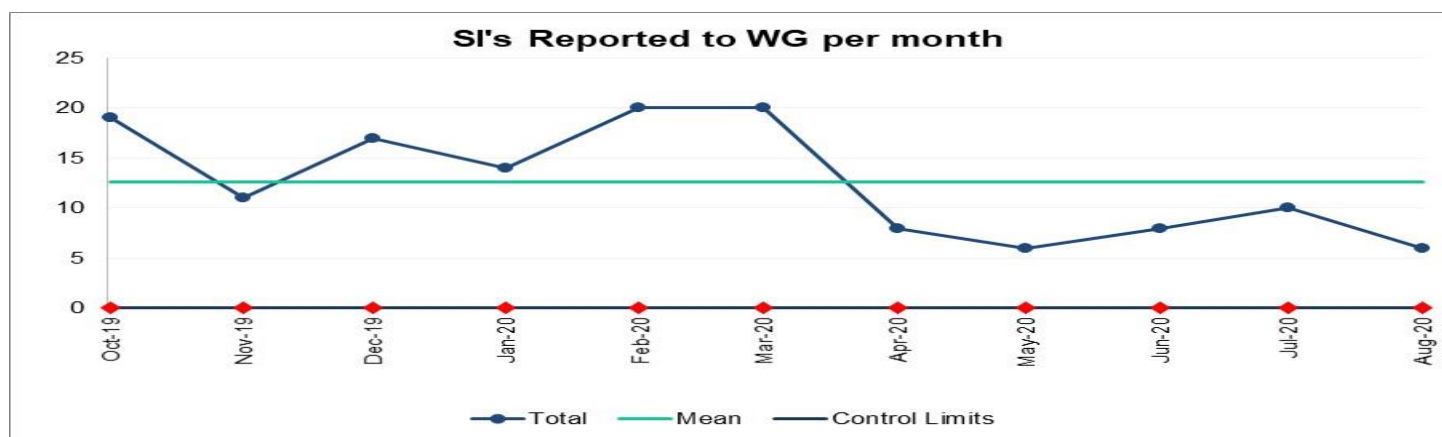


SI' Reported 1.10.20-31.10.20	
Diagnostic Processes/Procedures	1
Maternity Care	1
Neonatal/Perinatal Care	1
Patient Accidents/Falls	6
Therapeutic Processes/Procedures	2
Unexpected Deaths or Severe Harm	3



SI's Reported 1.10.19 - 31.10.19	
Diagnostic Processes/Procedures	2
Injury of unknown origin	1
Medical Devices, Equipment, Supplies	1
Neonatal/Perinatal Care	2
Patient Accidents/Falls	2
Therapeutic Processes/Procedures	1
Unexpected Deaths or Severe Harm	10

In comparison to the same period in 2019 the number of serious incidents reported to Welsh Government was higher (19). Serious incidents reported on a monthly basis are set out in the graph below by month. During the month of October 2020 the Health Board reported 14 Serious 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 from 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 NHS Delivery Unit in November (wrong component used). 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. 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.

#### **Learning from the four types of Never Events is summarised below**

#### **Recommendations**

- Clinical Lead identified within orthopaedics to prepare action plan in response to this alert
- Following review of X-Rays of all potential patients (352), one patient identified as having reconstruction plate fitted since 1<sup>st</sup> February 2018 that resulted in plate failure
- Reconstruction plates have previously been included on the tray system in orthopaedic theatres, and are now stored separately for use as required
- The labelling of the reconstruction plates has been made as clear as possible within theatres to ensure they are not used inappropriately
- Clinical Lead for Trauma & Orthopaedic Surgery to further reiterate at Orthopaedic Audit
- Theatre Manager has cascaded information to all groups of staffing including nursing and professions allied to medicine
- Review of LocSSIP for the prevention of wrong implant/prosthesis which is considered robust by theatre management.
- Orthopaedic surgeons and theatre staff were unaware of the risk of plate failure when utilising reconstruction plates. This was considered an unavoidable risk due to lack of knowledge at the time.

#### **Recommendations**

- Cardiac theatres should revert to accepted practice of having one scrub nurse and one circulating nurse responsible for all swab counts within theatre.
- Swab counts to only be performed by appropriately trained staff.

- Any changes within theatre practice to be discussed and agreed with cardiac senior staff
- Staff to undergo training on the Safety Brief and its importance of completing on TOM's prior to the surgery commencing.
- Review of governance practice and risk assessments prior to any change in practice.

## **Recommendations**

- Dental Practice to adopt a recognised "Local Safety Standards for Invasive Procedures" (LocSSIPs) for wrong tooth extraction in dentistry for all Dentists at the practice as well as sharing the learning with all performers, dental care professionals and support staff in the practice. A follow up support visit from the Dental Practice Advisor (DPA) to ensure action is embedded within the practice.
- IA to continue to implement the LocSSIPs approach in his future practice.
- Swansea Bay University Health Board to share the anonymised learning with Welsh Government, Health Education & Improvement Wales (HEIW), Local Dental Community (LDC), Local Health Board Quality & Safety groups and local practitioners via a newsletter and end of year practice visits.
- Swansea Bay University Health Board to continue to encourage all Swansea Bay UHB practices to adopt a LocSSIPs approach and encourage HEIW to recommend all Dental Foundation Trainee (DFT) practices to adopt a LocSSIPs.
- LocSSIPs to be recommended as part of conditional inclusion of EU/PLVEs (Performers List Validation by Experience) within a practice.
- HEIW examine how they notify and work collaboratively with Health Boards when patient safety issues are identified with trainees. A new reporting document has been issued to practices from HEIW but this does not offer any potential for triangulation(Appendix A). HEIW to work with Health Boards to examine whether there is any benefit in issuing guidance on DFTs involvement in IHAs.
- Dental Practice Advisor (DPA) support visit to ensure changes embedded within the practice to give the Health Board confidence and to develop agreed action plan to include audits on record keeping and LocSSIPs and any training needs within the practice are identified and implemented
- Swansea Bay University Health Board to review its Policy on In Hours Access patient appointment times and standards
- HEIW working with Health Boards to review how DFTs are involved in In Hours Access Patients.
- Dental Practices who host Foundation Dental Trainees to be fully aware of the HEIW Dental Significant Event Reporting Protocol.
- SBUHB review the Service Level Agreements (SLA) for In Hours Access (IHA) provision as to whether a basic base chart should be implemented for all patients seen through IHA and clarification on competence expectations of those delivering IHA sessions.

## **Recommendations:**

- Introduction of Safety Briefing at start of all invasive procedures with allotted appointment time.
- LocSSIPs to be written in keeping with NatSSIPs.
- Staff to undergo training on the Safety Brief and its importance.
- All staff to be included in Sign In process and confirmation of the site procedure.
- Review of current WHO checklist in collaboration with Cwm Taf Morgannwg External Clinical Leads.
- Consideration of pen marking of side before the patient lies on the table.

- Consideration of side marker on image intensifier.
- Consideration of use of split screen initially; one showing reference image with marker and the other screen showing live image of procedure for initial injection so that the radiographer is able to confirm the correct side of the procedure.
- All above to be considered for inclusion in reviewed policies and procedures.
- Review of LocSSIPs and other procedural documentation in conjunction with NatSSIPs to ensure compliance.

Following the Executive led Gold Command meeting, which reviewed the actions taken and lessons learned, an overarching improvement plan was developed and will be monitored by the Quality & Safety Governance Group.

## 5. Once for Wales Risk Management System

The Once for Wales Concerns Management System (OfWCMS) is a cloud-based risk and compliance management interface solution and will enable a step-change in managing quality, health, safety, environment, risk and compliance across the whole of NHS Wales. The key features 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.

All NHS bodies are required to report incidents on to the Datix software management system. Currently, all currently have varying versions and modules of the DatixWeb and DatixRichClient systems. Following a successful competitive tender, RLDatix Ltd were awarded the contract for 5 years, with an option to extend this period if required. The new solution is known as “DatixCloudIQ” and has many enhanced features compared to other systems.

The new DatixCloudIQ system will enable all NHS staff to report incidents/concerns/events and risks into the new RLDatix system through a log in weblink held on an organisations intranet page.

The new RLDatix system will be integrated with Active Directory Federation Services (ADFS) this is a new approach to how all NHS health boards and trusts in Wales currently login to Datix system/s. This functionality will enable staff to use their existing username and password credentials used to login to a PC on a daily basis, this will eliminate administrative burden and make Datix reporting a swift process. The Local System Leads will control access hierarchy to records within the system through security groups and profiles based on staff roles/ responsibilities and areas of work.

The Programme Timetable for implementation of the new DatixCloudIQ system is outlined in table1 below:

**Table 1 – Programme Timetable for Roll Out of the OfWCMS**

Phase	Function
<b>Phase 1</b>  <b>April 2021</b>	<ul style="list-style-type: none"> <li>• Incident Reporting, Capture, Coding and Management</li> <li>• Content and Update Governance</li> <li>• Migration of data for existing Datix systems</li> <li>• Training programme for Local System Leads</li> </ul>



	<ul style="list-style-type: none"> <li>• Code of Connection - NHS Wales Infrastructure and RLDatix</li> <li>• Active Directory/ADFS/Connection and Access to Cloud services</li> <li>• Integration with PAS/Empi and ESR</li> <li>• Risk Management</li> <li>• Cervica – Patient Experience system (replacing SNAP)</li> </ul>
<b>Phase 2</b>  <b>April 2022</b>	<ul style="list-style-type: none"> <li>• Datix RFI Functional Workstream continuity</li> <li>• Link with LARS Case Management System</li> </ul>

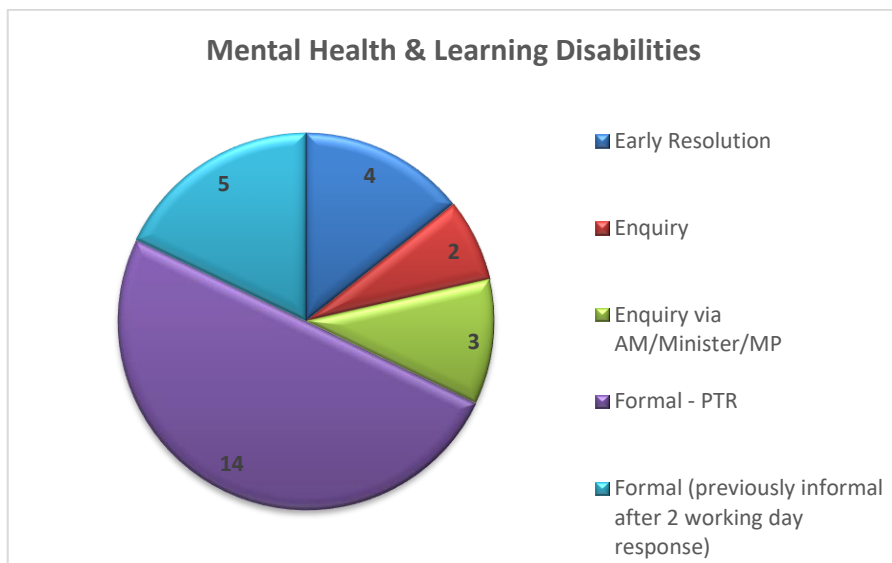
- The risk and assurance team are unable to meet the deadline of end of October 2020 for sending user export information to the O4WCMS team, as we have not received speciality information from Singleton/NPT. (we need to ensure that the Hierarchy list is up to date before the form can be finally completed. We are required to assign staff in our lists to specific areas by way of a location/area code. If the hierarchy list is not updated the staff will not have the correct access when they use the new system). This is logged as a high risk on the Datix Risk Log.
- The Datix User Group oversees the local implementation of the Once for Wales Concerns Management System. The group meet monthly and provide bi-monthly progress reports to the Quality and Safety Governance Group.

## 5. DELIVERY UNIT REPORTS

### Mental Health & Learning Disabilities Services Delivery Unit

1<sup>st</sup> October- 31<sup>st</sup> October 2020

Mental Health & Learning Disabilities SDU received 28 concerns.



#### Top Complaint Trends

- Communication (7)
- Medication (5)
- Clinical Treatment (3)



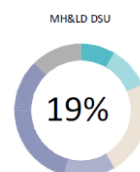
- No Never Events
- 0 Clinical Negligence claim
- 0 Personal Injury claim

#### Incidents:

246 incidents were reported with the 3 top themes being:

- Inappropriate/Aggressive Behaviour towards staff by patient – (61)
- Suspected Slips/Trips/Falls (unwitnessed) – (25)
- Witnessed Slips/Trips/Falls – (19)

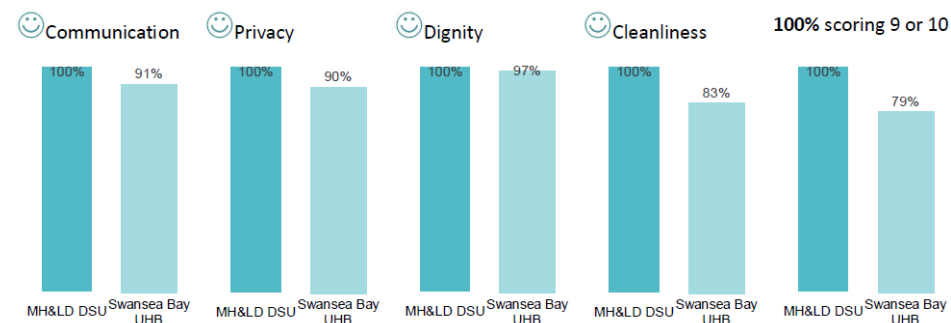
**2 Serious Incident's:** both relating to unexpected deaths



#### Friends & Family Results – October 2020

Of the 48 respondents, 9 said that overall their experience of the service was good or very good.

#### All Wales Survey

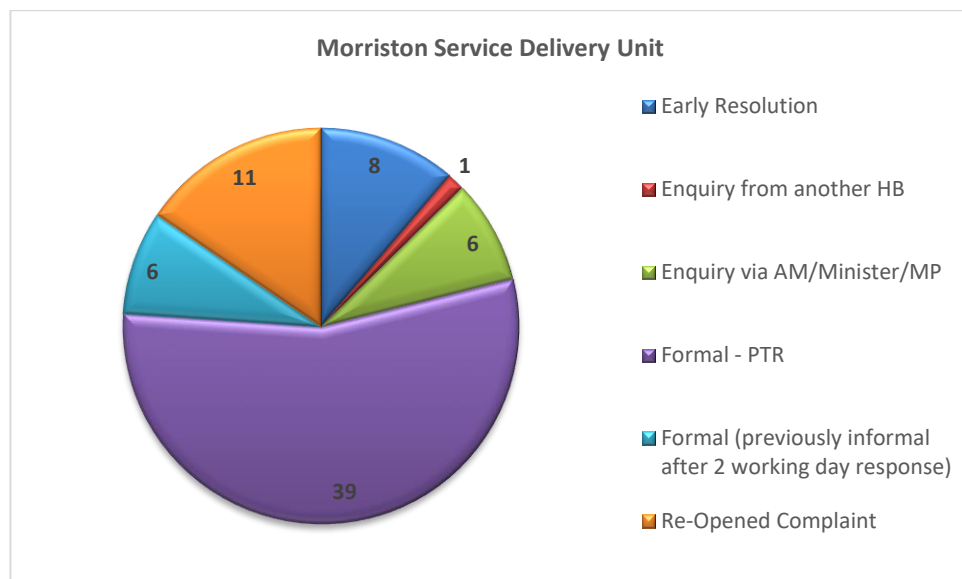


There was 1 All Wales Surveys completed for the Service Delivery Unit during October 2020.

# Morrison Hospital Service Delivery Unit

1<sup>st</sup> October– 31<sup>st</sup> October 2020

Morrison Hospital SDU received 71 concerns.



## Top Complaint Trends

- Communication (20)
- Admissions (14)
- Clinical Treatment (9)



- 8 Clinical Negligence Claims



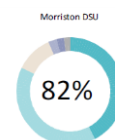
- No Personal Injury Claims
- No Never Events

## Incidents:

741 incidents were reported with the 3 top themes being:

- Moisture Lesion– (113)
- Suspected Slips/Trips/Falls (unwitnessed) – (56)
- Access & Admission – (48)

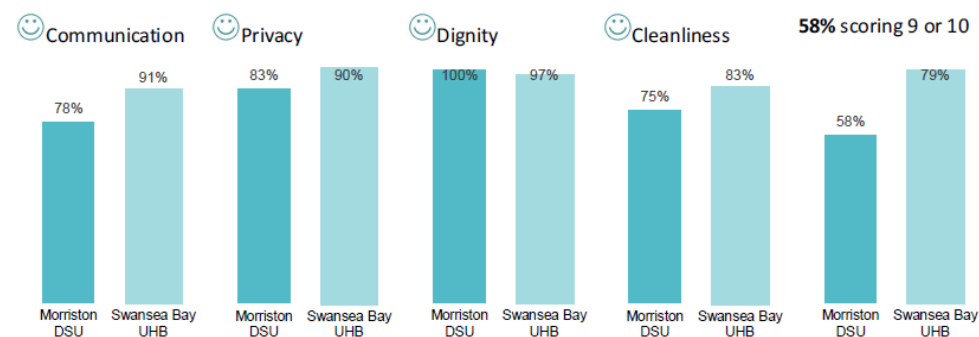
3 Serious Incidents were reported during October 2020 – 1 Unexpected Death, 1 Patient Fall and 1 Therapeutic Processes.



## Friends & Family Results – October 2020

of the 269 respondents, 221 said that overall their experience of the service was good or very good.

## All Wales Survey

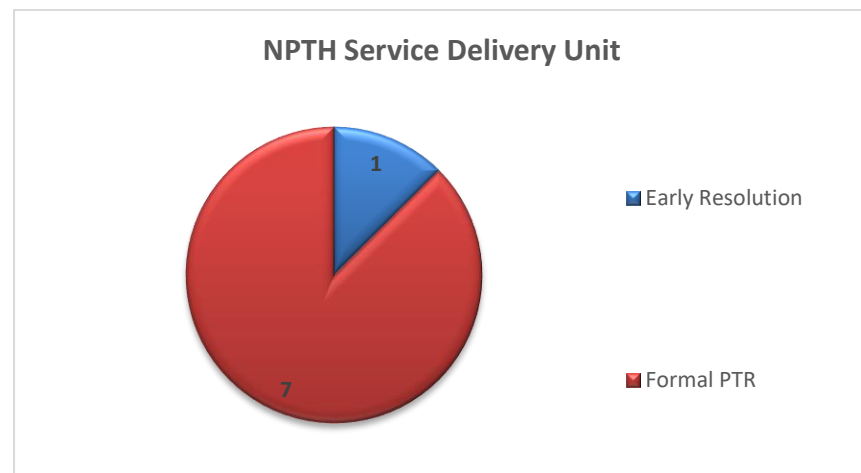


12 All Wales Surveys were received for the Service Delivery Unit during October 2020 with the overall score of 58%.

# Neath Port Talbot Hospital Service Delivery Unit

1<sup>st</sup> October– 3<sup>rd</sup> October 2020

Neath Port Talbot SDU received 8 concerns



## Top Complaint Trends

- Nutrition & Hydration (2)



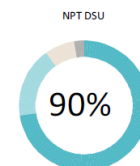
- No Personal Injury claims
- No Clinical Negligence claims
- No Never Events

## Incidents:

124 incidents were reported with the top themes being:

- Inappropriate/Aggressive behaviour towards staff by a patient – (23)
- Suspected Slips/Trips/Falls (un-witnessed) – (23)
- Human Resource Availability – (11)

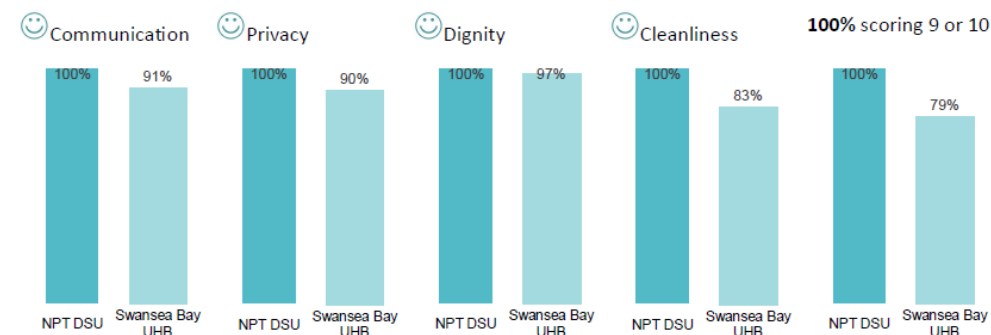
**1 Serious Incident was reported during October 2020 relating to Patient Accident/Falls**



## Friends & Family Results – October 2020

of the 40 respondents, 36 said that overall their experience of the service was good or very good.

## All Wales Survey

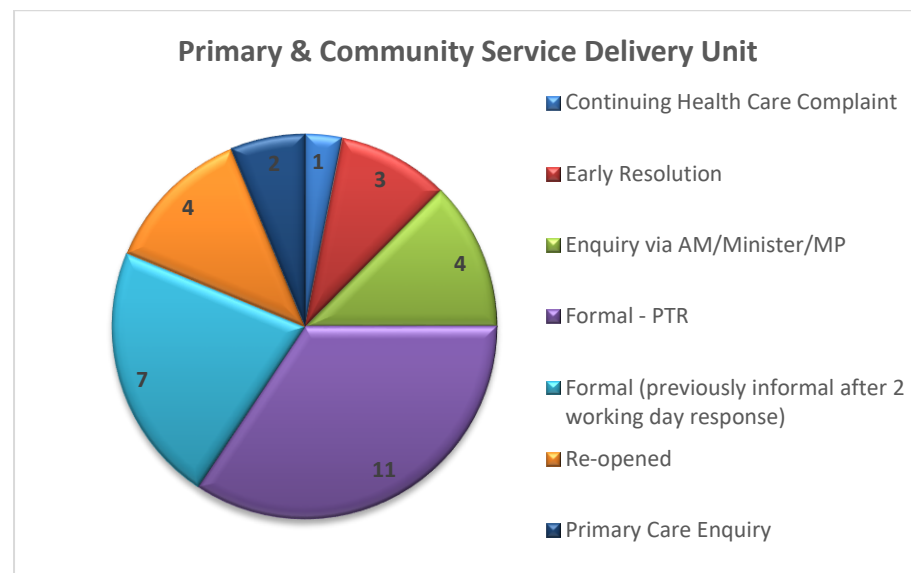


2 All Wales Survey was received for the Service Delivery Unit during October 2020 with the overall score of 100%.

# Primary & Community Service Delivery Unit

1<sup>st</sup> October– 31<sup>st</sup> October 2020

Primary & Community SDU received 32 concerns.



## Top Complaint Trends

- Communication (11)
- Appointment (4)



- No Personal Injury claims
- No Never Events



- 2 Clinical Negligence Claims

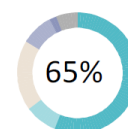
## Incidents:

259 incidents were reported with the 3 top themes being:

- Moisture Lesion- (61)
- Pressure Ulcer – developed prior to admission (54)
- Pressure Ulcer – developed in current clinical area (31)

2 Serious Incidents were reported, 1 Diagnostic Processes and 1 Therapeutic Processes

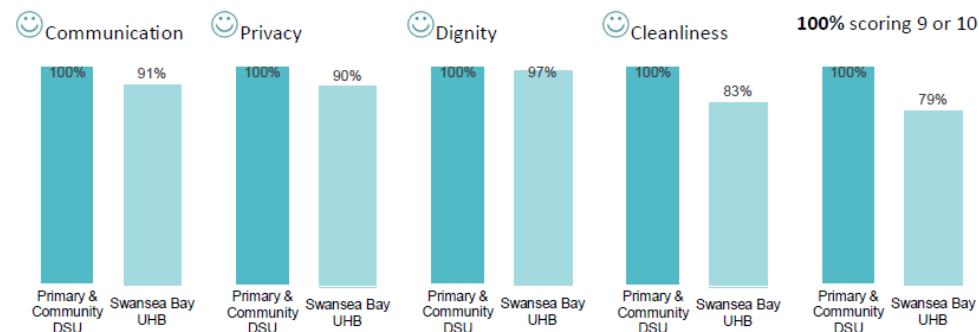
Primary & Community DSU



## Friends & Family Results – October 2020

of 208 respondents, 135 said that overall their experience of the service was good or very good.

## All Wales Survey

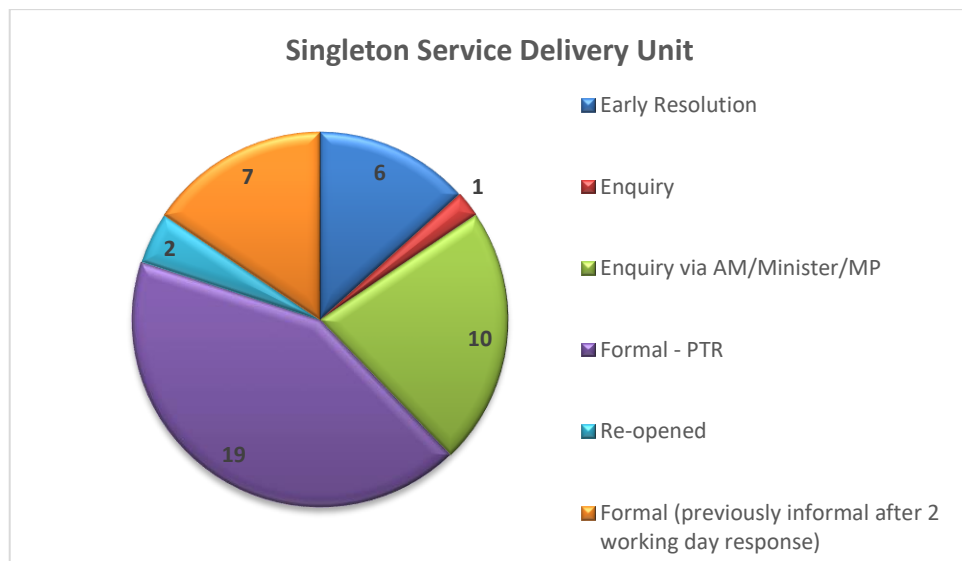


4 All Wales Surveys were received for the Service Delivery Unit during September 2020 with the overall score of 100%.

## Singleton Hospital Service Delivery Unit

1<sup>st</sup> October- 31<sup>st</sup> October 2020

Singleton Hospital SDU received 45 concerns.



### Top Complaint Trends

- Communication (11)
- Clinical Treatment (8)
- Appointments (8)



- 0 Personal Injury Claims
- 0 Clinical Negligence claims



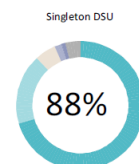
- 1 Never Event

### Incidents

401 incidents were reported with the 3 top themes being:

- Maternity Triggers – (49)
- Moisture Lesion (36)
- Pressure Ulcer developed prior to admission (21)

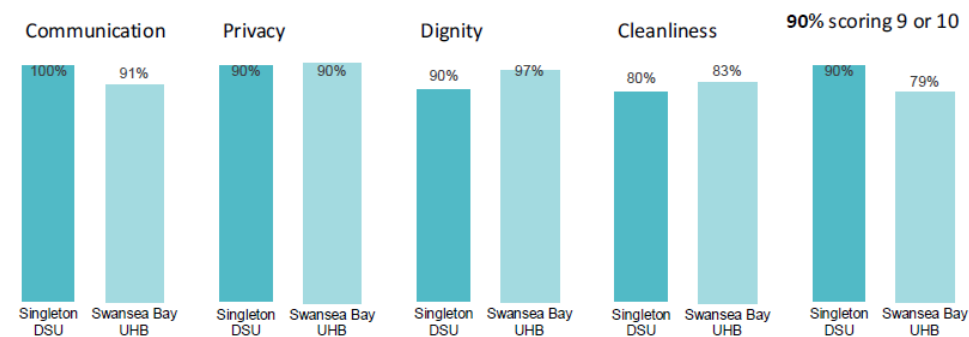
**6 Serious Incidents were reported during October – 4 Patient Falls, 1 Maternity Care and 1 Neonatal Care**



### Friends & Family Results – October 2020

of 530 respondents, 467 said that overall their experience of the service was good or very good.

### All Wales Survey



10 All Wales Surveys were received for the Service Delivery Unit during October 2020 with the overall score of 90%.