Patient Experience, Risk & Legal Services
Report
April 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 the development of the new feedback system, Civica, there is very limited feedback.

For the month of April 2021 there were 785 Friends and Family online survey returns (the responses are mainly from Gorseinon MVC x 451, Bay fiend MVC x 335) which resulted in 99% of people stating they would highly recommend the Health Board to Friends and Family which was a 12% increase from March 2021.

From the 785 responses received the high response areas across the reporting period (all with 100% positive feedback) included:

- Acute Clinical Team – NPT Hospital (1 response)
- Bay Baglan School – Community (1 response)
- Bay Blood Testing Service – Community (8 responses)
- Cardigan Ward - Morriston Hospital (3 responses)

The 10 lowest scoring (Below 90%) areas for the reporting period (1st April to 30th April 2021) were:

There were no areas with responses below 90%.

1.2 Patient Experience Team

Civica the new Patient feedback system: The New Patient Feedback System is in the final stages of set up. This includes adding users and setting alerts, and reports. The F&F and All Wales Surveys are available as an online link only at present (soft launch). SMS is due to start by 10th May (this date is a provisional test date and may change).

A comprehensive staff training schedule will be implemented when the system is complete and has data on the platform so staff can fully experience the system and its capabilities. This will be complimented with a Civica training intranet page/posters and staff bulletin.

Paediatric surveys have been developed which now incorporate 'child friendly images'; (teddy bears and staff fish etc).

To date there are 17 bespoke surveys on the waiting list to be developed.

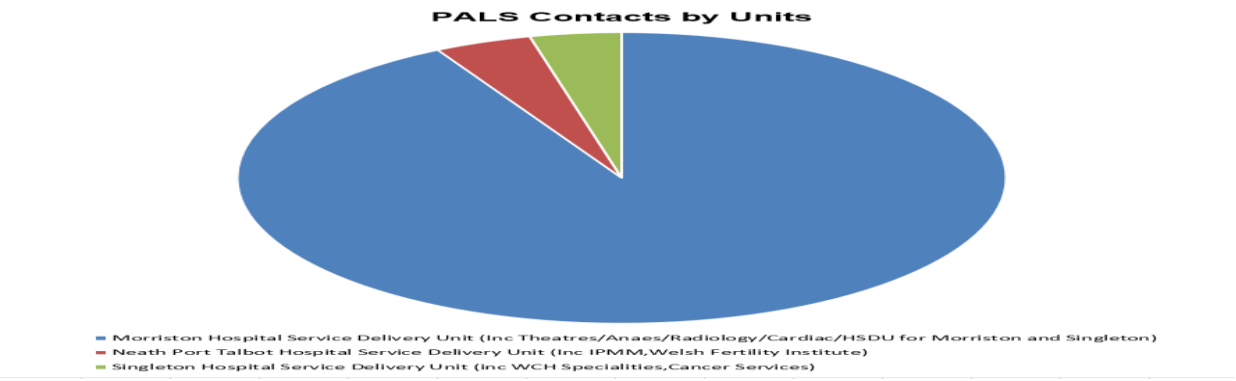
The team behind Attend Anywhere platform are also looking to include the F&F link in the virtual appointments system.

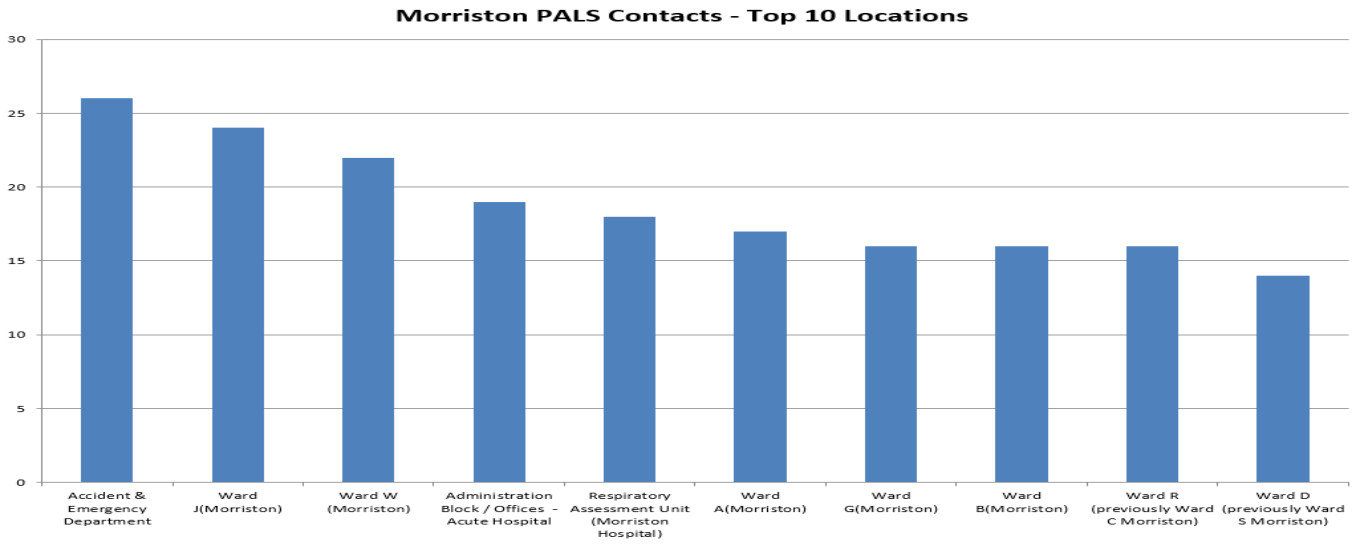
The F&F link has also been updated to the new platform across 2,475 iPads. The F&F App is currently in 'test flight mode' with Apple, once signed off we will load this to the app store and our kiosks across the organisation.

1.3 Patient Advisory Liaison Service (PALS) Activity – April 2021

During the month of April 2021, the Health Board's PALS Teams recorded 391 records on the Datix system, this compared to a total of 725 contacts for March 2020.

These are broken down by each PALS Team/Delivery Unit below, Morriston having the highest number with 360 contacts.

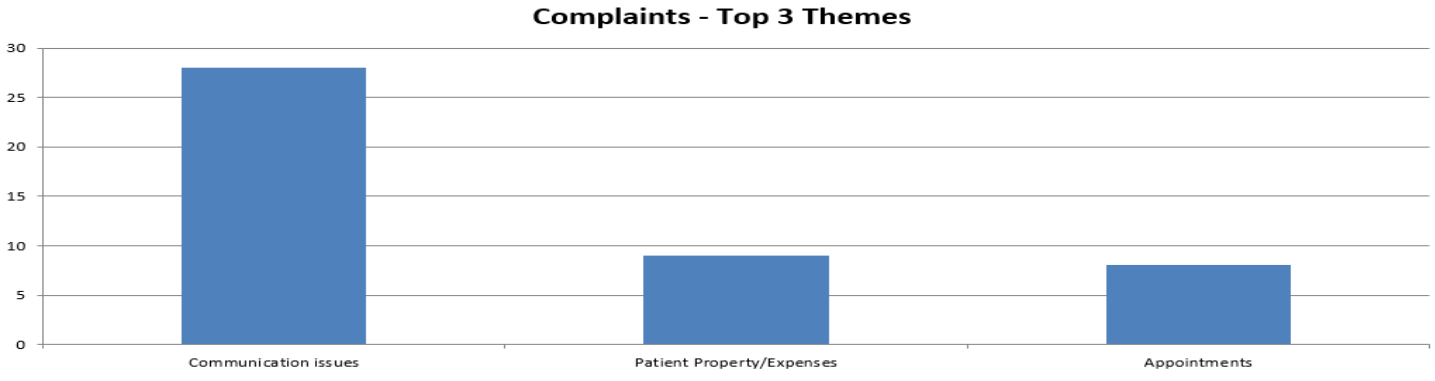




The PALS teams deal with a variety of different situations ranging from complaints to compliments, below shows the contacts by type;

Advice	4	Bereavement	16	Comment	4	Compliment	15
Information	81	Support	182	Help	15	Concern	74

Out of the 74 concerns received via the PALS Team, the top complaint issues are below;



1.4 All Wales Patient Experience Questionnaire

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

Reduced numbers of returns due to Covid

There was no data for April 2021 due to changing systems

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

You were given help with feeding and drinking											
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
100%	0%	0%	80%	40%	76%	75%	100%	50%	86%	83%	92%

Were you given the support you needed to help with any communication needs?											
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
100%	93%	82%	87%	89%	83%	90%	100%	64%	89%	89%	94%

Were things explained to you in a way that you could understand?											
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
95%	100%	92%	94%	87%	76%	89%	89%	76%	90%	92%	97%

Did you feel we did enough to keep you as free as possible from pain?											
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
100%	100%	67%	89%	79%	85%	81%	76%	60%	80%	83%	93%

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

People are welcoming, friendly and helpful?											
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
100%	100%	67%	90%	91%	83%	96%	81%	67%	86%	87%	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?											
Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
100%	80%	67%	86%	83%	84%	71%	86%	70%	80%	84%	81%

2. LEARNING FROM FEEDBACK

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

‘Let’s Talk’ – April 2021

The Datix Risk Management system is used to log, store, and track the Swansea Bay Let’s Talk data/information. This enables the Health Board to use this data when looking at themed reports. For April there were 63 contacts. 12 were converted to complaints; 1 compliments and 3 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’

No feedback from social media.

There was no comments from Care Opinion for April 2021.

I Want Great Care

We received 3 pieces of feedback for ‘I Want Great Care’ in April 2021. Two were for Morriston and one was for Neath Port Talbot hospital.

Morriston

- I was a patient in 2017. The staff and the level of care they provided were amazing and made my pain much more bearable. There are two areas I wasn't happy with. The first was the food, it was awful. Tasteless, repetitive and had little nutritional value. The tuna pasta bake was so overcooked you couldn't pick it up with a fork. Maybe if the food had better nutritional values patients might heal more efficiently. The second gripe was the lack of outside green areas. The car park surrounded everything so going outside as a means of relaxation just never happened. During a long hospital stay like mine patients need some tranquillity to help their recovery. They don't need to listen/observe to lots of car drivers all vying for car parking spaces making and shouting obscene comments and gestures at each other.

- Excellent care by all staff, but particularly those of Cyril Evans ward, where I spent most of my time. Courteous, fun-loving, attentive staff who made my visit so much easier. Thanks to you all.

Neath Port Talbot Hospital

- I have recently attended the hospital for a discectomy back operation under *Consultant*. I would like to thank *Consultant* and the operation team for their professionalism and care, and for giving me once again the pain free mobility I was used to prior to my back issue. The care at ward B2 was second to none, all of the staff from the cleaners, catering, nurses, physio and all the doctors were friendly and caring, and nothing was too much trouble. A very professional team and a credit to the hospital which made a potentially uncomfortable experience as comfortable and pleasant as possible. Thank you.

2.1 Learning from Events

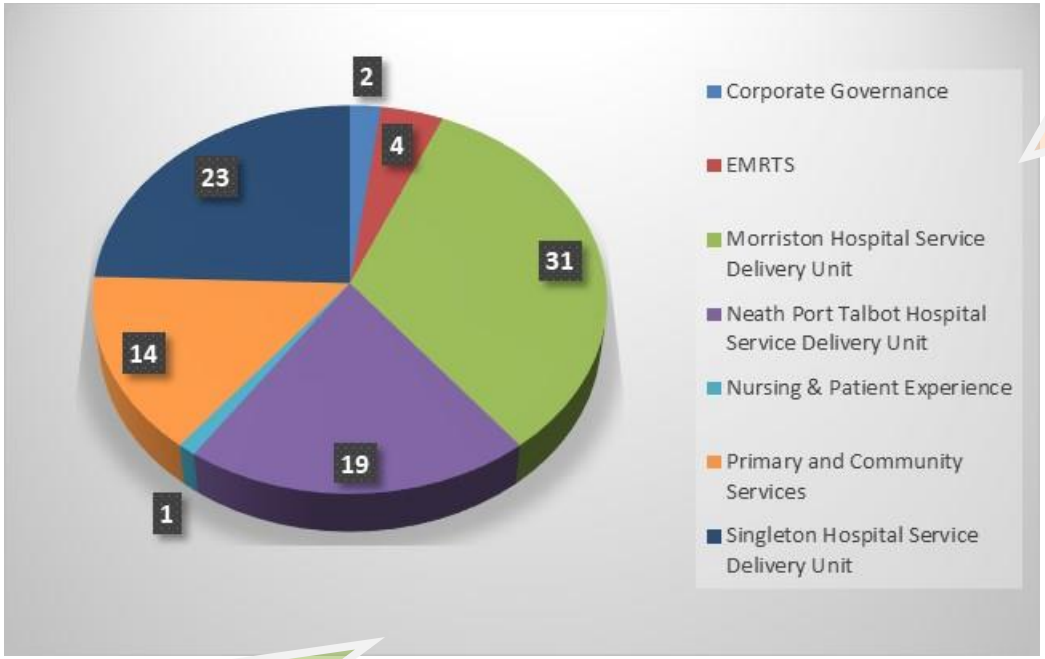
This section of the report will include learning from events for example: SI's, incidents, complaints, claims, inquests and Redress cases. The Learning from Events will be issued using the RL Datix alerts module to ensure the Service Groups receive them.

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 94 compliments were recorded on Datix between 1st April 2021 and 30th April 2021, a breakdown by the Delivery Units is provided on Page 8 and a selection of compliments received.

3.2 Written Compliments – April 2021



"At the time of attending, I was feeling anxious about the procedure to be taken. The nurse and Doctor were both sensitive to how I was feeling and explained and put me at ease. Please extend my most grateful to them for taking so much time and not making me feel stupid or a nuisance during this most stressful time for all hospital staff. They are a credit to your hospital and to the NHS."

Ophthalmology, Singleton Hospital

"A big thank you for all the care and attention you gave to my daughter. Much appreciated. Keep up the good work. You are all angels."
Minor Injury Unit, Neath Port Talbot Hospital

"Just to advise that I had my first dose of the Covid-19 vaccine at The Orangery this morning and was very very impressed by it all. I wanted to pass on that the staff were all amazing at every stage of my appointment – from arrival at the gate in the car, right up to leaving the park afterwards.
I hope they have been getting amazing feedback as everyone certainly deserves it!"
Mass Vaccination Centre, Nursing & Patient Experience

Thanks for the exceptional care received by the ACT over Easter weekend. The team were excellent, professional and punctual and their skills second to none.
Acute Clinical Team, P&C Services

"I have been to The Bay this evening to have my COVID-19 vaccination and I just wanted to say thank you to everyone involved in the vaccination process for Swansea Bay UHB - all of your staff have been amazing and couldn't have been more helpful (from initial booking right through to this evening)."
Bay Field Hospital, Corporate Governance

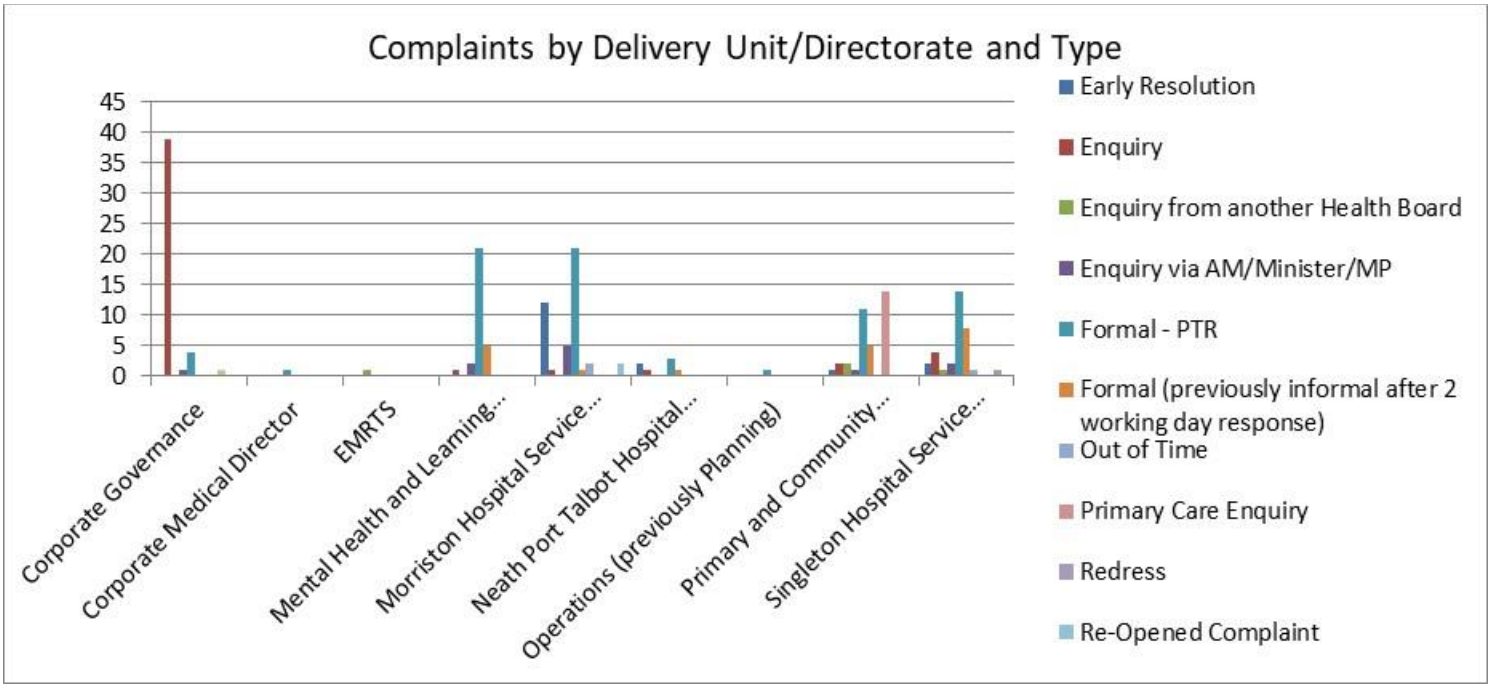
Letter of gratitude received from the wife of a patient - "Great admiration for the work the Welsh Air Ambulance do" A £500 donation to Wales Air Ambulance was enclosed.
EMRTS

4. CONCERNS MANAGEMENT

4.1 Complaints – April 2021

Complaints 1.4.21 – 30.4.21

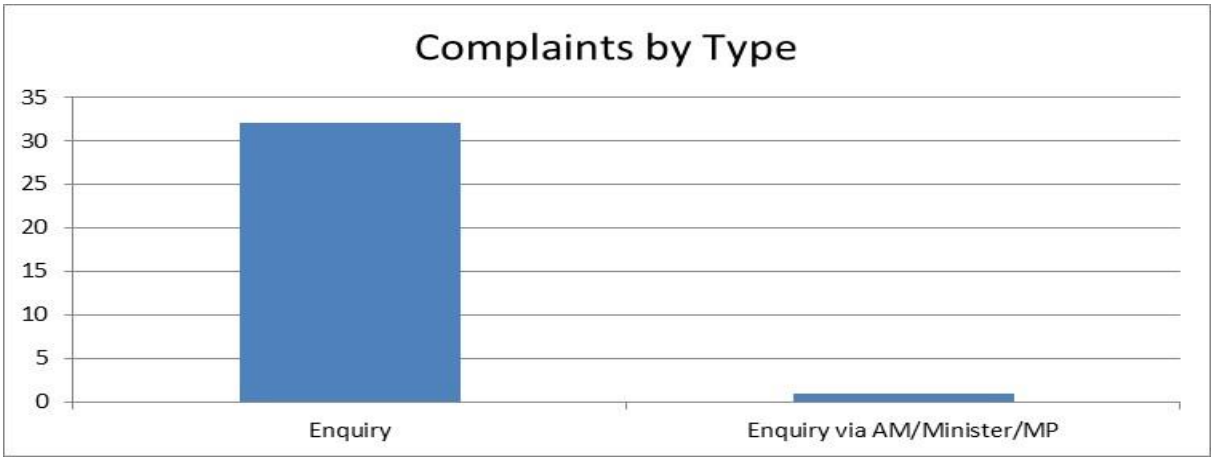
The Health Board received 200 complaints during the month April 2021, please see breakdown by unit and type below;



Out of these 200 complaints, 33 related to COVID-19, please see subject breakdown below;

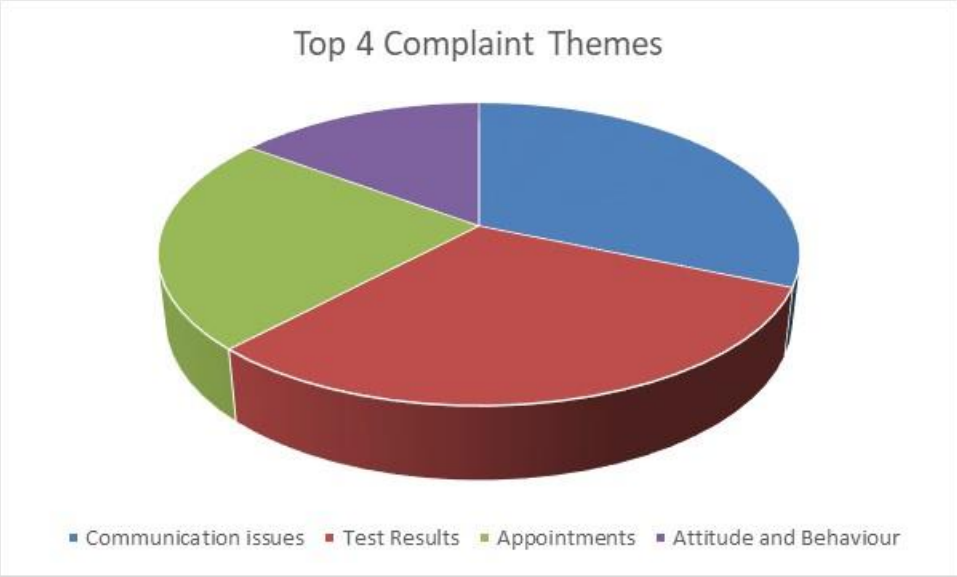
Acquired COVID-19 during admission	3
Cancellation of treatment/appointment/Clinic due to COVID-19	1
Access to other treatment	27

During April 2021, the Health Board received 33 enquiries/complaints regarding the COVID-19 Vaccine, see breakdown of type below;

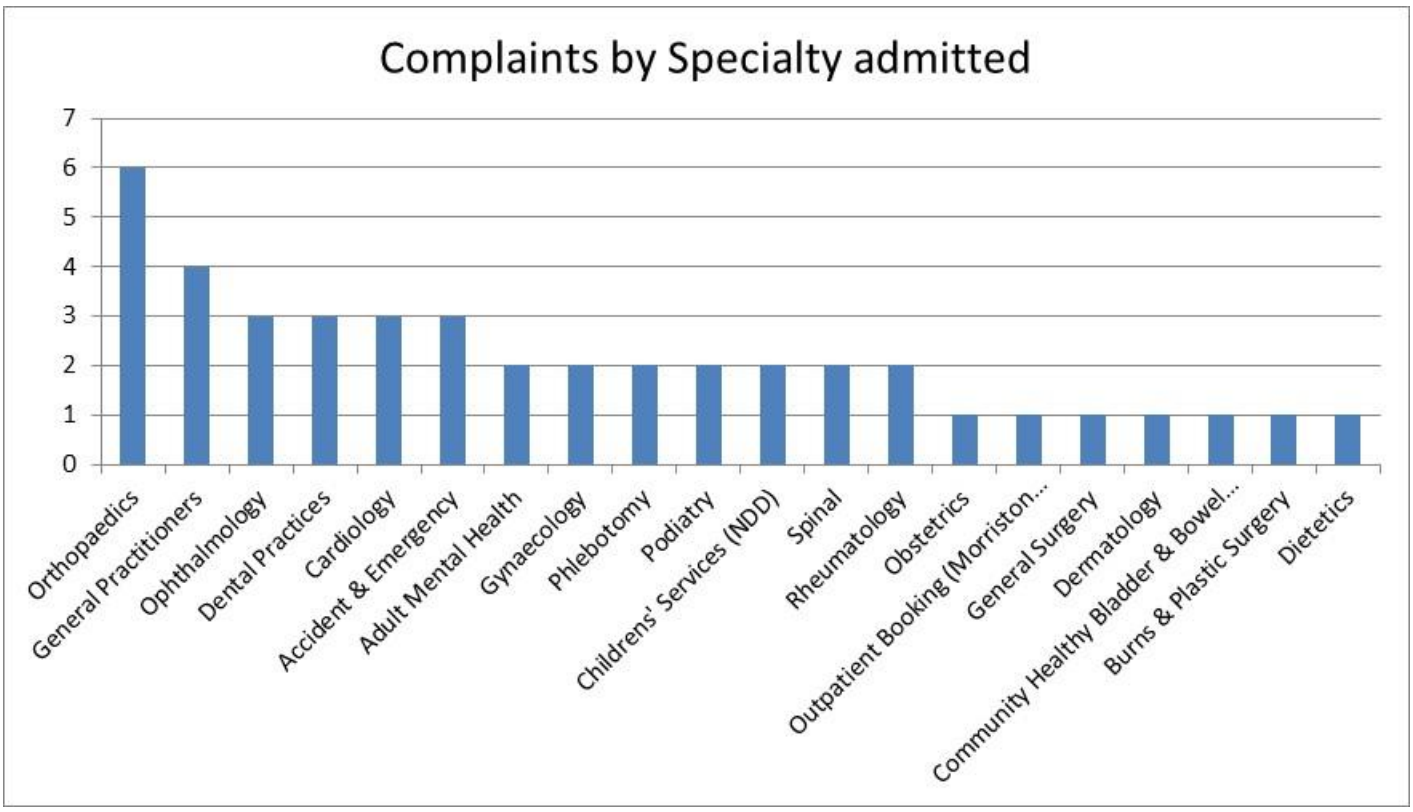


The Complaints Team are currently supporting the Vaccine Enquiry Inbox, they are reviewing all communications into the Health Board and ensuring that they are responded to in a timely manner.

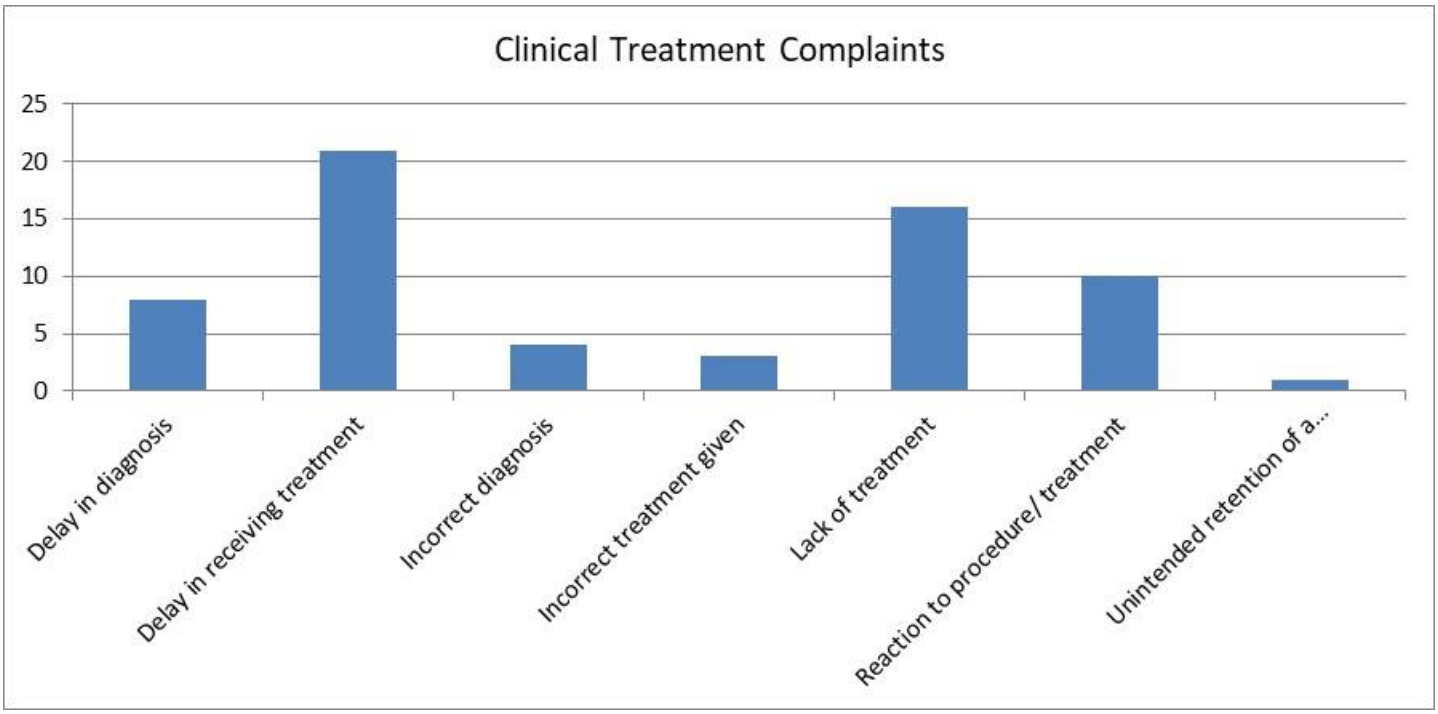
Top 4 Complaint Themes



During April there were 46 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

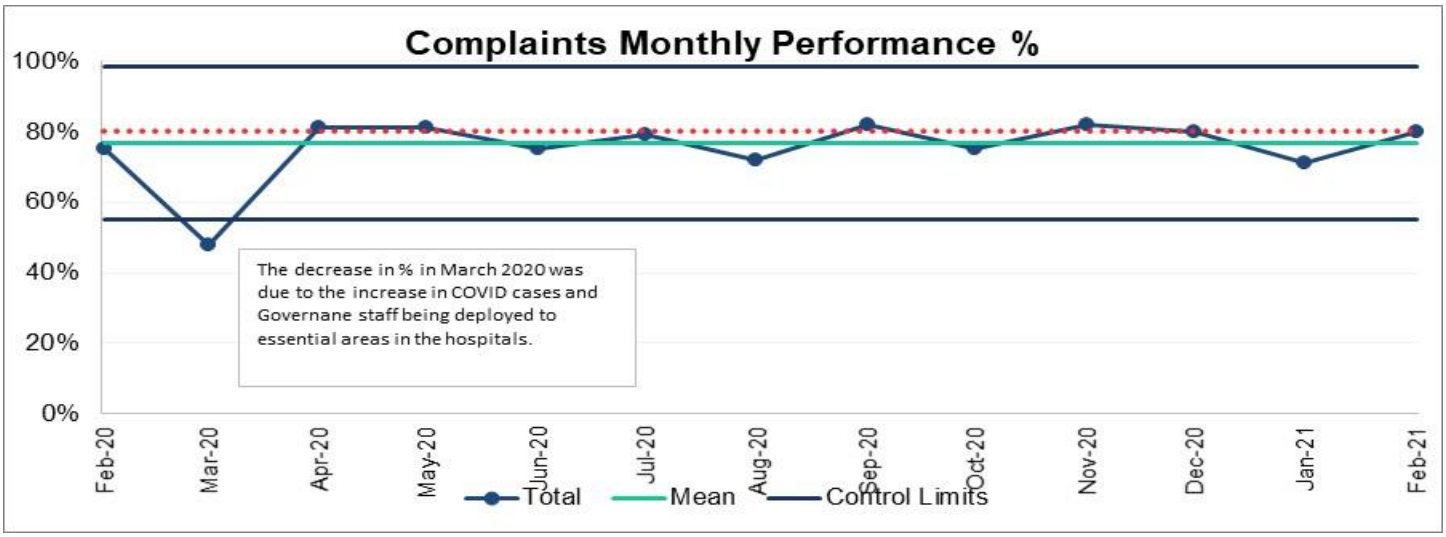
On a monthly basis, the Health Board conducts a Concerns Redress Assurance Group (CRAG) where the Corporate Complaints Team review recently closed complaints. A 'deep dive' review is undertaken on each Service Groups in turn, as well as the review of a selection of closed complaints from the other Service 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 is due to be held with Morriston Q&S Team on 14th May 2021. Initial review of the cases is positive and all complaints had been responded to appropriately and in compliance with the Regulations.

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 February 2021. The Welsh Government Target is 75%.



4.4 Ombudsman Cases

There was a slight decrease in complaints which the Ombudsman investigated in relation to the Health Board in 2020/21, 18 compared to 30 in 2019/20. There was one new investigation received during April 2021.

The Ombudsman provided Complainants Standards Training to Governance Teams on 9th and 18th March 2021. The training has already been successfully delivered and we are looking at arranging further more specified training going forward.

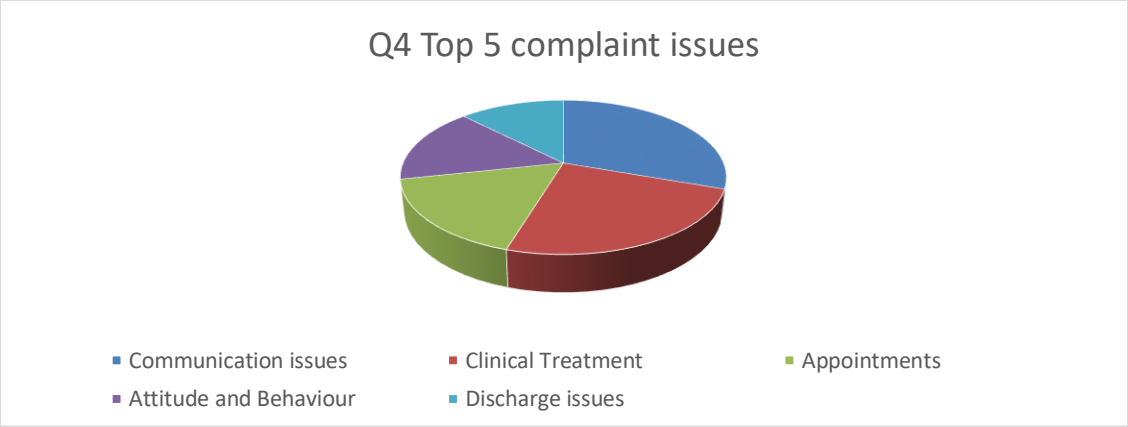
4.5 Concerns Actions taken/being taken include:

- 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.
- Human Rights training for Mental Health & Learning Disabilities is currently taking place via 4 sessions due to a recommendation from the Ombudsman. This is being provided remotely via Teams by the British Institute for Human Rights.

Q4 complaints received

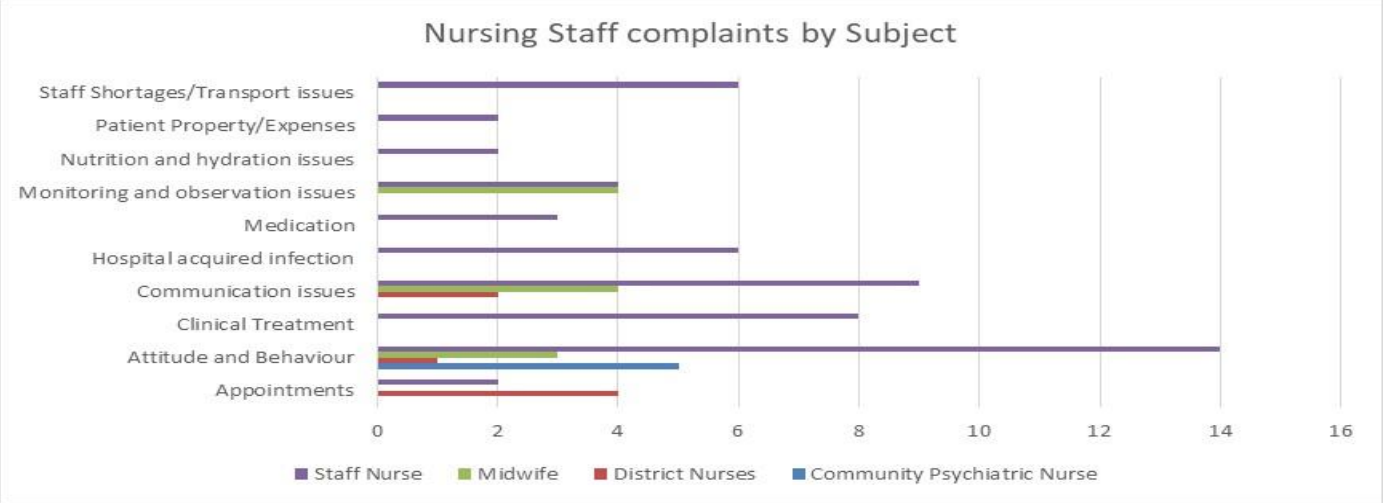
- Out of all complaints received during Q4, the top five complaint themes are shown below;



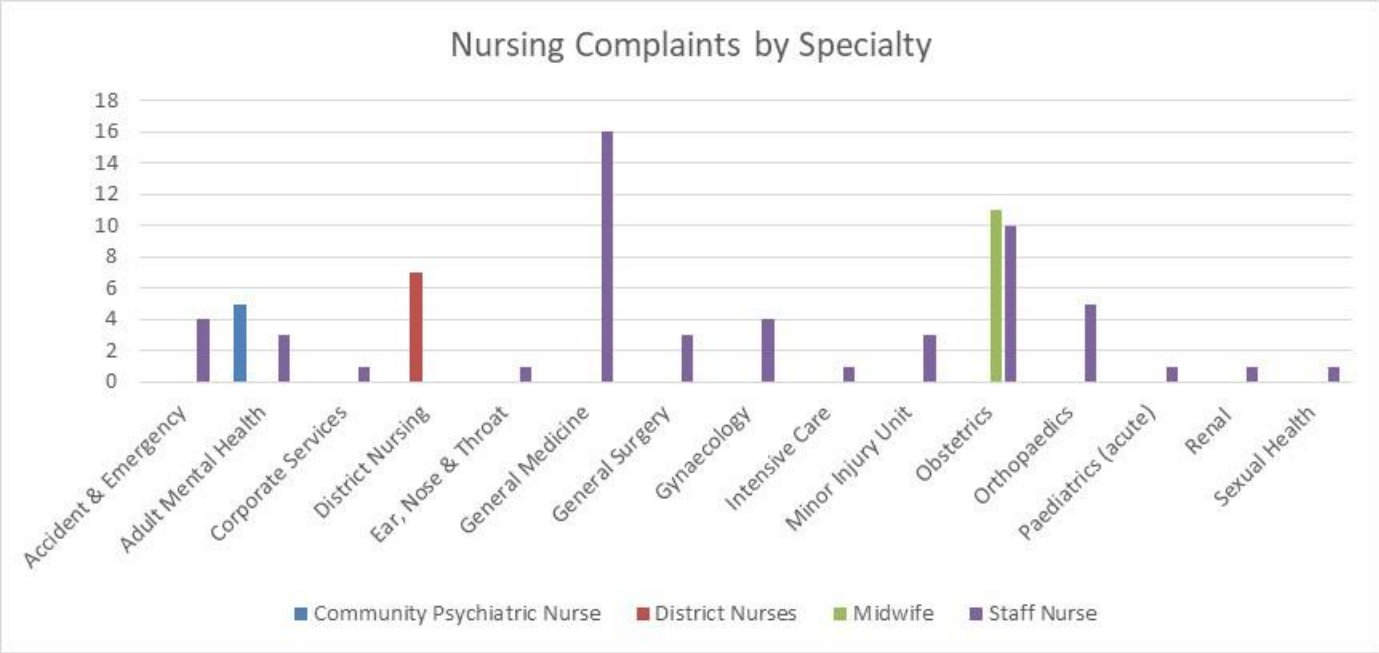
Nursing Professions – out of all complaints received for Q4, the complaints involving nursing staff are broken down by subject and specialty below.

The graph below shows the main issues relating to nursing staff are;

- Attitude & Behaviour
- Communication Issues



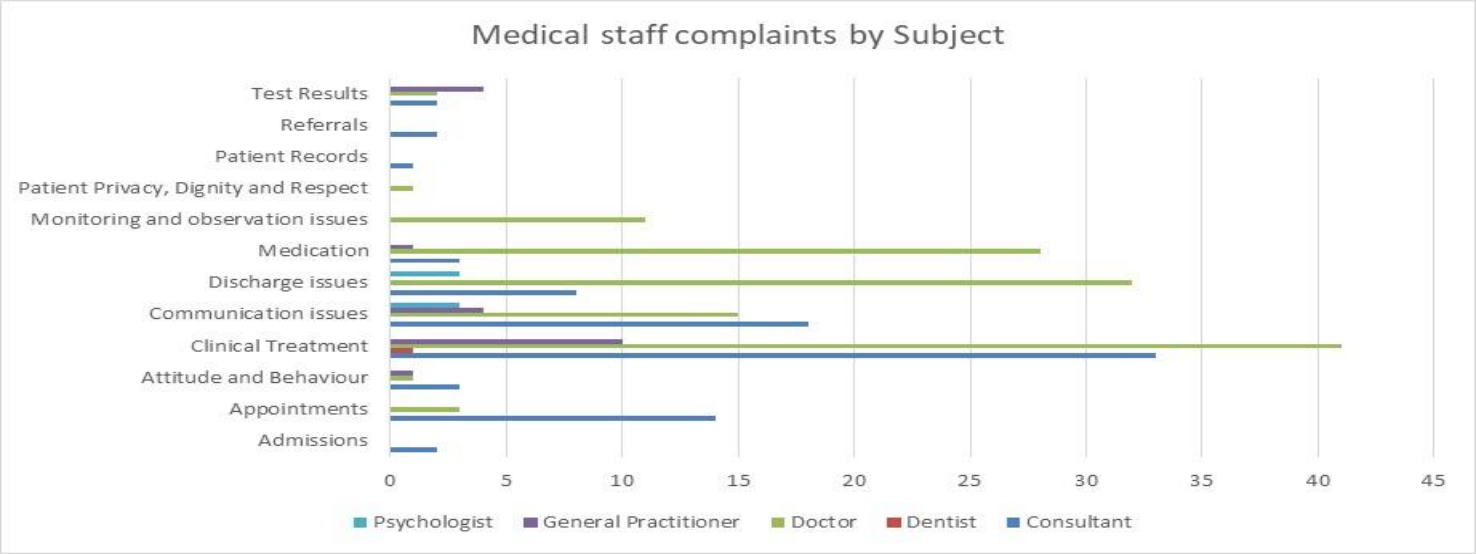
The graph below then shows the areas with the most complaints about nursing staff are General Medicine and Obstetrics.



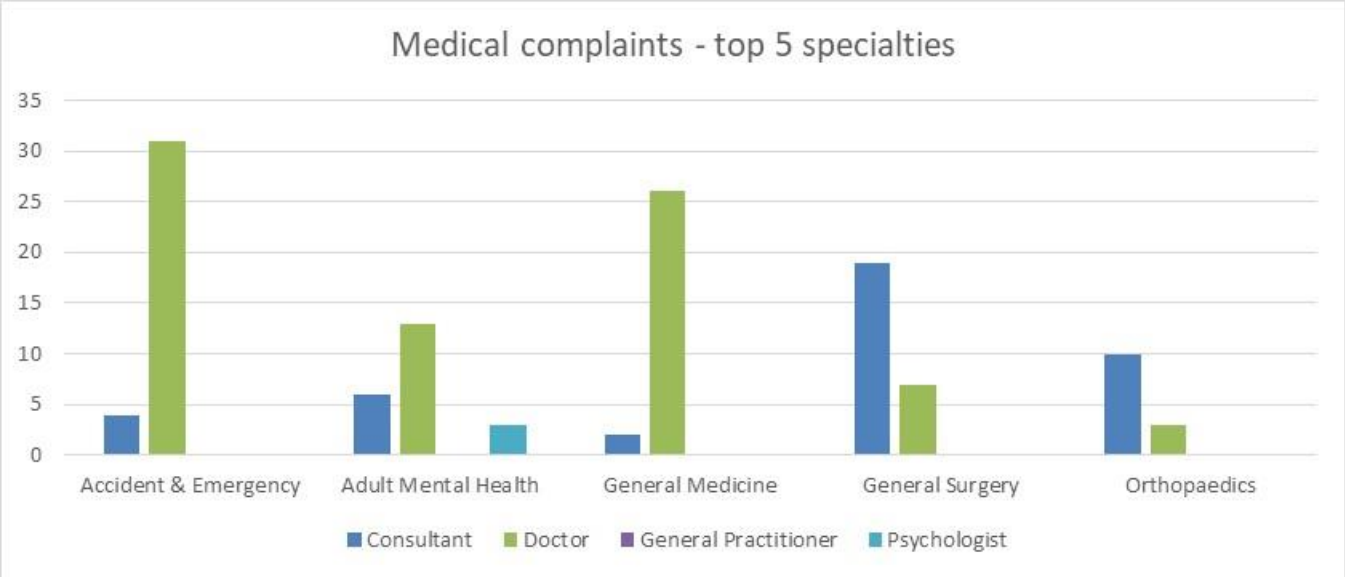
Medical Professions – out of all complaints received for Q4, the complaints involving medical staff are broken down by subject and specialty below.

The graph below shows the main issues relating to medical staff are;

- Clinical Treatment
- Discharge Issues
- Communication Issues
- Medication



The medical staff complaints include many different specialties therefore, the graph below shows the top 5 specialties with the most medical complaints;



4.5 Incidents

4.5.1 Incident Reporting & Performance

For the period 1 April 2021 to 30 April 2021, a total of 1,772 incidents were reported (March was 1,768). The severity of the level of harm of incidents reported is set out as follows:

Severity of Harm	Incidents Reported
No Harm (1)	1288
Low (2)	353
Moderate (3)	113
Severe (4)	2
Death (5)	16
Total	**1772**

The top five themes relate to:

Incident Type Tier One - Top 5	No	
Injury of unknown origin	254	14.33%
Pressure Ulcers	222	12.52%
Patient Accidents/Falls	203	11.45%
Behaviour – Patient affected	142	8.03%
Behaviour (including Violence and Aggression) – Staff affected	140	7.9%

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 254 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	105
SBUHB acquired Moisture lesion	75
Injury of unknown origin	74
Total	**254**

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 74 cases identified 16 incidents which had been incorrectly coded. These cases have now been updated and coded correctly as follows:

Pressure Ulcer	6
Patient Accident/Fall	3
Communication	1
Moisture Lesion	4
Therapeutic processes	1
Behaviour (suicide attempt)	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.

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

There are 2404 incidents and 47 Redress (in the March report there were 3425 incidents, therefore, this has decreased quite significantly)

Following roll out of the new system 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.

	Incident	Redress
Corporate Governance	20	20
Corporate Medical Director	5	0
EMRTS	4	0
Finance	1	0
Mental Health and Learning Disabilities Delivery Unit	336	0
Morriston Hospital Service Delivery Unit	1148	9
Neath Port Talbot Hospital Service Delivery Unit	113	2
Nursing & Patient Experience	4	0
Operations (previously Planning)	82	0
Primary and Community Services	231	0
Princess of Wales Hospital Service Delivery Unit	3	2
Singleton Hospital Service Delivery Unit	424	14
Workforce & Organisational Development	33	0
Total	2404	47

4.5.2 SI's Reported 1st April 2021 to 30th April 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;

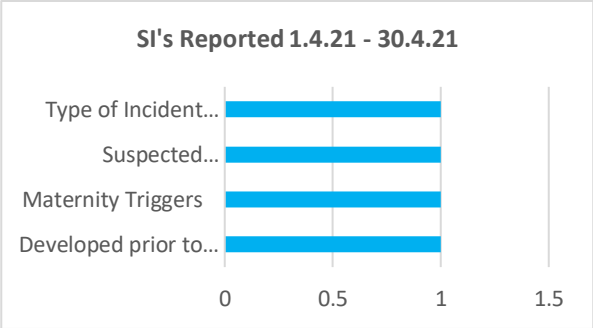
- all never events
- in patient suicides
- maternal deaths
- neonatal deaths
- homicides
- incidents of high impact / likely to happen again including child related deaths (for local decision)
- Covid-19 nosocomial transmission; these do not require reporting individually as SI's but will continue to 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.

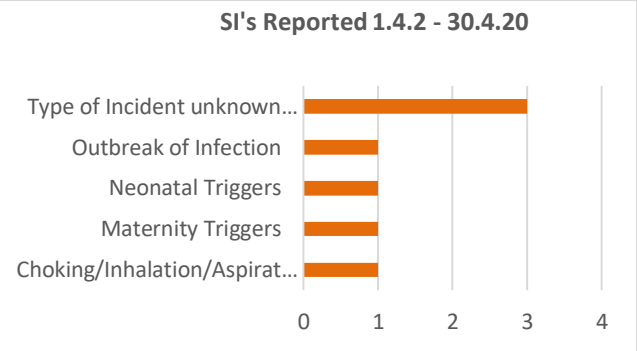
- As a reminder **CORSEL** is in place which requires the Health Board to identify learning from Covid cases to be shared with Health Boards via a report to the NHS Delivery Unit. All notifications are to be sent to the Health Boards Serious Incident Team for reporting.

- During April 2021 a total of 4 serious incidents were reported to Welsh Government, see breakdown below;

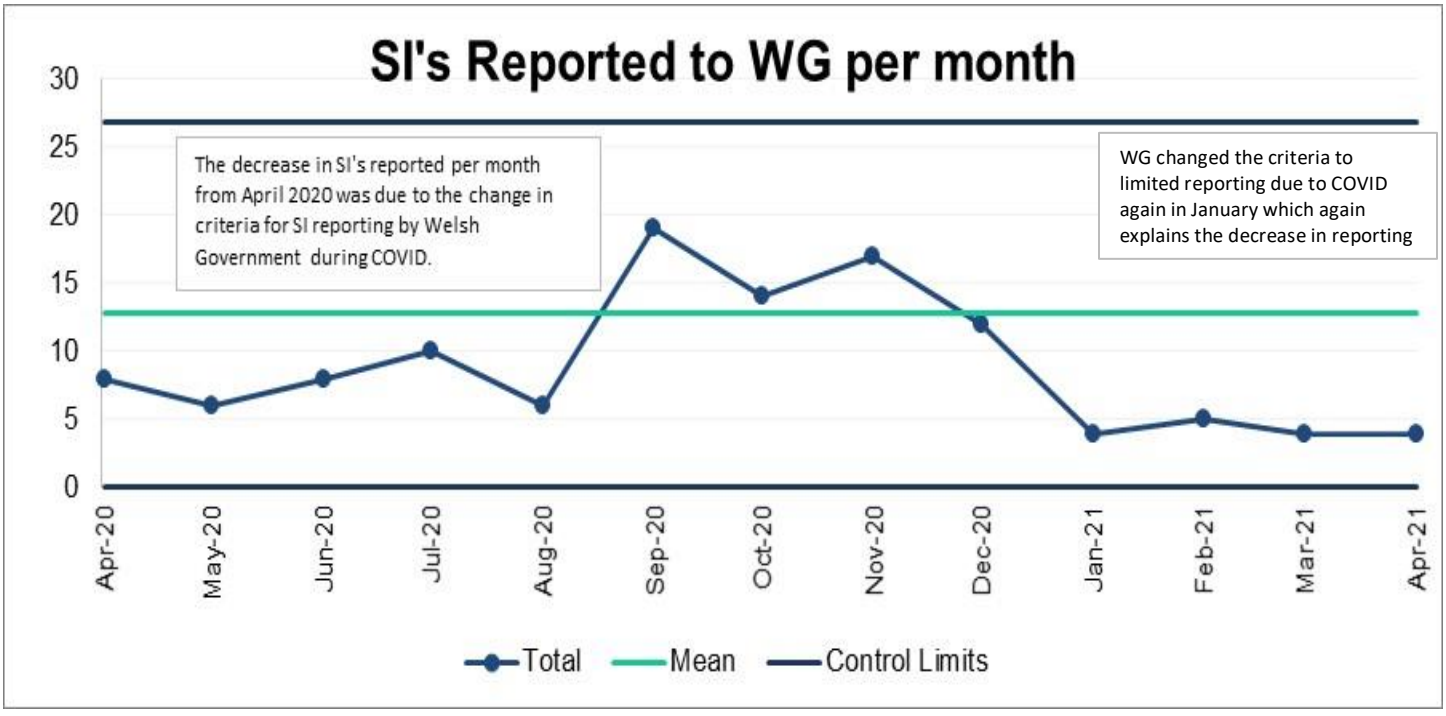
• SI's Reported 1.4.21 - 30.4.21	
Developed prior to admission to current clinical area/caseload	1
Maternity Triggers	1
Suspected Slips/Trips/Falls (un-witnessed)	1
Type of Incident unknown at time of reporting	1



SI's Reported 1.4.2 - 30.4.20	
Choking/Inhalation/Aspiration	1
Maternity Triggers	1
Neonatal Triggers	1
Outbreak of Infection	1
Type of Incident unknown at time of reporting	3



In comparison, the number of serious incidents reported to Welsh Government was higher in April 2020 with 7 Serious Incidents reported. Serious incidents reported on a monthly basis are set out in the graph below by month. During the month of April 2021 the Health Board reported 4 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 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 2020/21 the Health Board reported three never events to Welsh Government relating to:

- Wrong Implant/Prosthesis
- Retained Foreign Object – two 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 2020/21

During the year three 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 last Never Event was reported to Welsh Government on the 19th November 2020 (Wrong implant/Prosthesis).

Learning from Closed NE's

Lessons Learnt;

- Official swab counts to be conducted whenever swabs are used, whether for procedures or examinations
- Only Raytec swabs to be used
- Documentation to be fully and accurately completed by staff
- The Midwifery Led Unit is classed as a low risk unit but they must also follow all the guidelines and procedures that adhere to the Labour & post-natal wards
- Policies and procedures are put in place for a good reason and should be followed by all staff in all areas

- Patients to be transferred to the Labour ward if medical input is required.
- MLU to work to the same standards as the Labour ward and post-natal ward. Swab counts fully completed for all swabs used, documented in patient notes and counter signed by two members of staff.
- Both midwifery staff and medical staff to ensure that documentation is fully completed before the end of their shifts
- All staff to count swabs before and after the examination/procedure

Recommendations:

- All non raytec swabs to be removed from the Midwifery Led Unit or placed in a clearly marked area so that they are not used for examinations/procedures
- All staff to be reminded about the importance or official swab/instrument counts whenever swabs/packs are used
- Senior staff to complete six monthly audits on patient records where swabs/packs are used to check for compliance with official swab/instrument counts and record keeping
- Learning of incident is disseminated to all midwives to raise awareness about the risk of retained foreign objects
- Safety brief to be issued to the relevant areas – (Appendix 3)
- All staff to be reminded about the protocol of transferring patients that require medical review.
- The Guidelines for management & repair of perineal trauma to clearly include that swabs used for examination purposes also apply to the official swab count protocol and to be noted in patient records with a clear swab count noted and countersigned.
- All staff to be made aware of the importance of recording keeping and noting of any swabs/packs used on patients for any reason.
- Audits to be completed to ensure staff compliance with record keeping for swab use
- All maternity staff to be reminded that all areas must adhere to the same policy and procedures with official swab counts
- A dedicated container to be used so that the swabs can be separated during counting, and the swabs are not to be removed until all counts are reconciled.
- The guidelines for perineal repair & trauma to include the need for swab counts for examinations as well as procedures.
- Only raytec swabs that are detectable on radiography and have safety features, such as tails or tags to be used for any examinations/procedures

- Any non- raytec swabs to be removed from the MLU or placed in a separate area and clearly marked as non-raytec swabs.
- Audit/stock take the type of swabs on the MLU.
- All staff to be made aware that swabs used to procedures/examinations are to be raytec only swabs.

Lessons Learnt;

- The importance of ensuring correct anaesthetic staffing levels within the Burns Unit.
- The importance of maintaining communication with the main anaesthetic and critical care service when experiencing staffing deficits.
- The importance of ensuring correct anaesthetic staffing levels within the Burns Unit.
  The importance of maintaining communication with the main anaesthetic and critical care service when experiencing staffing deficits.
- The importance of using of arterial line sets with longer guidewire lines. The use of a longer line would protrude from the cannula therefore it would be impossible to connect to the arterial line set until the guidewire was removed
- All lines should be reported on radiology films

Recommendations;

- Closer working relationship needs to be developed between Anaesthetic and Critical Care Services to create appropriate increased Health Board capacity options to provide adequate cover for Burns Unit.
- Closer working relationship needs to be developed between Anaesthetic and Critical Care Services to create appropriate increased Health Board capacity options to provide adequate cover for Burns Unit.
- Procurement team to identify a companies who can supply arterial line sets with longer guidewires. This would constitute a forcing function which would be regarded as the most effective way of preventing retention of guidewires.
- The reporting of all lines on radiology films has been reiterated to the reporting Radiologist.
- The Never Event incident to be discussed at future Radiology Education meetings and staff to be requested to report all lines on radiology films.

5. Once For Wales Update

The OFW Team handed over SBUHB's O4W system on 7th May 2021. A period of testing will now be undertaken by the Local System leads to ensure user profiles are set up appropriately as well as locations, services and security groups. It is anticipated that the Health Board will go live on 1st July 2021.

Background

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. 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.

5. SERVICE GROUP REPORTS

Mental Health & Learning Disabilities Services Group

1st April – 30th April 2021

Mental Health & Learning Disabilities SG received 29 concerns.

Top Complaint Trends

- Clinical Treatment (4)
- Attitude & Behaviour (4)
- Communication (4)
- Medication (4)

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

Incidents:

283 incidents were reported with the 3 top themes being:

- Inappropriate/Aggressive Behaviour towards staff by patient – (69)
- Self-harming behaviour – (36)
- Inappropriate/Aggressive Behaviour by patient towards patient – (32)

1 Serious Incident relating to a Patient Fall

Friends & Family Results – April 2021

There is no F&F or All Wales data for April due to the new Cirvica system development.

Morriston Hospital Service Group

1st April – 30th April 2021

Morriston Hospital SG received 44 concerns.

Top Complaint Trends

- Admissions (11)
- Communication (9)
- Attitude & Behaviour (7)

- No New Never Events
- 0 Personal Injury Claims

- 10 Clinical Negligence Claims

Incidents:

569 incidents were reported with the 3 top themes being:

- Moisture Lesion – (6)
- Suspected Slips/Trips/Falls (unwitnessed) – (59)
- Access & Admission – (51)

0 Serious Incidents were reported during April

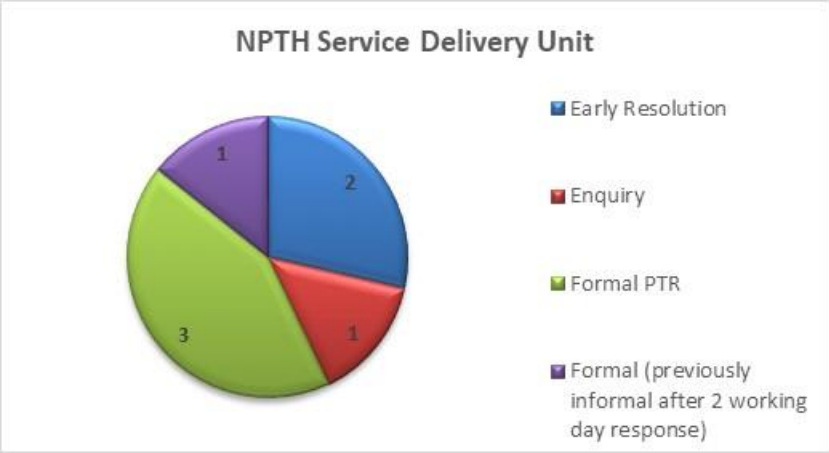
Friends & Family Results – April 2021

There is no F&F or All Wales data for April due to the new Cirvica system development.

Neath Port Talbot Hospital Service Group

1st April – 30th April 2021

Neath Port Talbot SG received 7 concerns.



Top Complaint Trends

- Appointments (3)

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

Incidents:

78 incidents were reported with the top themes being:

- Suspected Slips/Trips/Falls (un-witnessed) – (22)
- Suspected Slips/Trips/Falls (witnessed) – (9)
- Inappropriate behaviour towards staff by a patient – (8)

No Serious Incidents were reported during April 2021

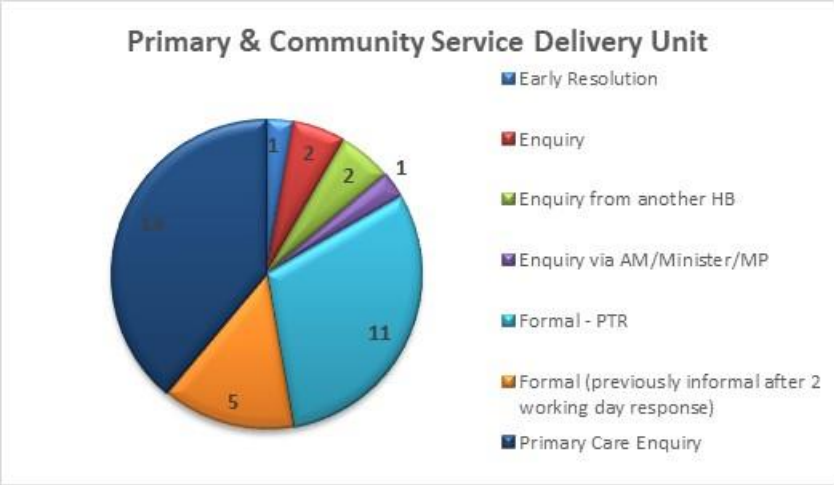
Friends & Family Results – April 2021

There is no F&F or All Wales data for April due to the new Cirvica system development.

Primary & Community Service Group

1st April – 30th April 2021

Primary & Community SG received 36 concerns.



Top Complaint Trends

- Appointments (11)
- Communication (10)

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

Incidents:

322 incidents were reported with the 3 top themes being:

- Pressure Ulcer – developed prior to admission (122)
- Moisture Lesion- (68)
- Injury of unknown origin (19)

2 Serious Incidents were reported during April 2021 – one unexpected death and one pressure ulcer

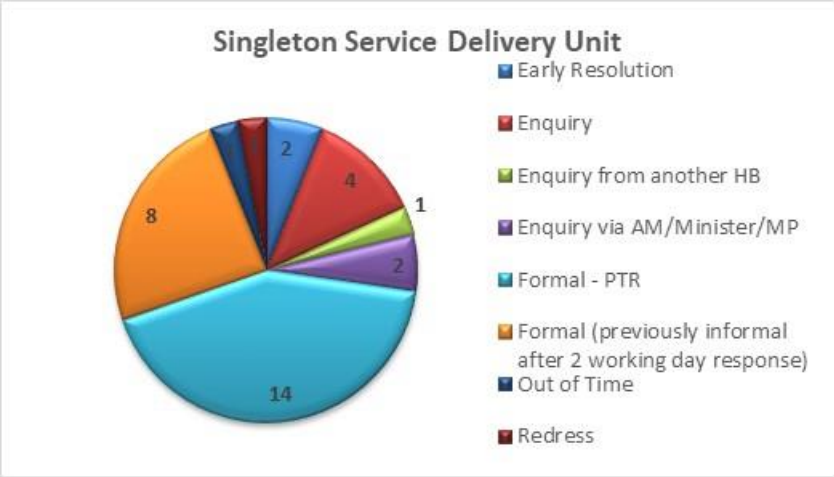
Friends & Family Results – April 2021

There is no F&F or All Wales data for April due to the new Cirvica system development.

Singleton Hospital Service Group

1st April – 30th April 2021

Singleton Hospital SG received 33 concerns.



Top Complaint Trends

- Communication (7)
- Appointments (6)

- 0 Personal Injury Claims
- 0 Never Events

- 3 Clinical Negligence claims

Incidents

442 incidents were reported with the 3 top themes being:

- Maternity Triggers – (47)
- Moisture Lesion - (36)
- Pressure Ulcer – Developed in current clinical area - (28)

One Serious Incidents was reported during April relating to Maternity care

Friends & Family Results – April 2021

There is no F&F or All Wales data for April due to the new Cirvica system development.