GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Our ref: [redacted]

7 May 2021

Ms Caroline Saunders
Room 204W
The Civic Centre
Godfrey Road
Newport
NP20 4UR

Dear Ms Saunders

Re: Regulation 28 Report received by Aneurin Bevan University Health Board further to the inquest touching on the death of Mrs Elizabeth Joyce Robinson.

Thank you for your report of 12 March 2021, outlining your concerns following the inquest of Mrs Elizabeth Robinson. I am sorry that it has been necessary for you to raise these concerns and I seek to address these in this response.

1. Staffing levels on Oakdale Ward, Ysbty Ystrad Fawr

Aneurin Bevan University Health Board (ABUHB) has processes in place across its sites to escalate any staffing deficits within a planned roster and/or any requests for additional staffing requirements. At the time of Mrs Robinson's fall, a Nurse Staffing Escalation Policy (NSEP) was in place. This articulates everyone's responsibility to maintain appropriate nurse staffing levels and sets clear actions if there is a deviation from what is required. Having reviewed the roster on the night of 20-21 October 2019, when Mrs Robinson fell on Oakdale Ward, it is noted that the planned nursing roster was met. There is clear evidence, by way of the health roster, that there was a request for additional staffing to support the provision of enhanced care and that this was escalated, acted upon by the Ward Sister, sent to the resource bank and the shift was subsequently filled to support this requirement. Therefore all reasonable steps were taken to manage the known staffing deficits.

The Health Board acknowledges that enhanced care is a challenge and consequently, in September 2020, established an Ysbty Ystrad Fawr (YYF) Health Care Support Worker (HCSW) pool, in order to support the enhanced level of care required.

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Ysbyty Sant Cadog
Ffordd Y Lodj
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Staff were employed on a substantive basis, as opposed to a temporary basis, therefore improving continuity in care and patient safety.

A very recent triangulated approach to review Community Ward establishments in YYF has been undertaken by the Head of Nursing for Nevil Hall Hospital (NHH) and YYF. The purpose of this is to review the current ward establishments and determine if they are fit for purpose to meet the acuity and dependency of patients, considering all available quality metrics to inform and support additional requirements. In line with the Nursing Staff Levels (Wales) Act 2016 (NSLWA), a full acuity audit will take place during the month of June. This will provide essential intelligence to support a triangulated re-calculation in August 2021, to determine appropriate nurse staffing levels on all Community Wards in YYF. YYF has been proactive in its approach to determine patients' acuity and commenced acuity capture as of April 2021 to determine workforce requirements. By way of assurance, the Health Board has in place the following to review and maintain nurse staffing levels:

- A NSLWA Operating Framework and Staffing Escalation Process, the purpose of which is to standardise and inform staff groups of their responsibilities also of processes and procedures for ensuring appropriate and carefully considered nurse staffing in all areas.

- A weekly reporting and escalation process by means of the Executive Safety Huddle by which all staffing deficits across the Health Board are reported. A comprehensive report is shared, which includes any incidents resulting in harm which may have been attributed to nurse staffing levels.

- The establishment of HCSW pools on Community Hospital sites to support the deployment of staff – taking all reasonable steps to ensure planned rosters were maintained on a backdrop of significant absenteeism and fluctuation in capacity required to manage the pandemic.

The recruitment strategies deployed within ABUHB to address the vacancy factor has placed the Health Board in a far more positive position. March 2021 reports a vacancy factor of 165.45WTE Registered Nurse vacancies – with a projected forecast of 121.32WTE vacancies by August 2021.

In addition to the extensive work on the recruitment of Registered Nurses the Health Board has also supported a significant move to increase the substantive HCSW workforce across all specialities. An additional 145WTE HCSW's have been employed since July 2020, providing continuity in care and improved patient experience.

2. Serious Concerns report findings

Unfortunately, in this instance, the investigation report into the events leading to Mrs Robinson's death was not shared with the staff involved in a timely manner. However, a falls thematic review for Ysbty Aneurin Bevan (YAB)

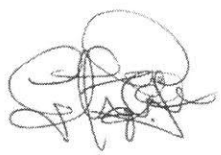
and YYF was established following this incident and interim post-fall guidance has been widely shared with medical and nursing staff across the Health Board to ensure awareness of, and compliance with Health Board policy. Whilst the report itself was not shared with the staff involved, the broader findings have been shared widely.

Serious Incident investigations can be undertaken by an individual Division or by the Health Board's Corporate Serious Incident Team, which is part of the Putting Things Right Team. An example of good practice is the Mental Health and Learning Disabilities Division which meets fortnightly to review unexpected deaths, serious incidents, safeguarding matters and other concerns, ensures that patients, family members and staff members involved in an incident are supported following often distressing incidents and that staff involved are provided with feedback on any incident report findings.

Nonetheless, it is acknowledged that there has been some variation within the Health Board as to how investigations are carried out as some investigations are carried out by the Health Board's Corporate Serious Incident Team, whilst others are carried out by individual Divisions. To address this, the Corporate Serious Incident Team has been working hard to create a standard approach for its own use and for the Divisions to follow. This has involved implementing a training programme for Investigating Officers to ensure that investigations are carried out thoroughly. This programme was temporarily paused during the second wave of the pandemic whilst clinical work was prioritised, but has recently recommenced. In addition, the Team is trialling standardised template agendas for use at Serious Incident investigation meetings to act as prompts to ensure that key points such as sharing report findings with stakeholders and with individual staff involved are implemented. A copy of these is enclosed. These templates will be reviewed, modified to reflect any feedback from the trial phase, and shared for use across the Health Board.

I trust that this information addresses the concerns raised in your report, however please do not hesitate to contact me should you require any further information.

Yours sincerely



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