Enw'r Pwyllgor: **Name of Sub-Committee:**	Exception Report from Listening and Learning Sub-Committee
Cadeirydd y Pwyllgor: **Chair of Sub-Committee:**	Paul Newman, Chair
Cyfnod Adrodd: **Reporting Period:**	December 2022
Materion Ansawdd, Diogelwch a Phrofiad: **Quality, Safety & Experience Matters:**	

The Sub-Committee met in October 2022 and received a number of presentations and individual cases from across the concerns and safeguarding portfolio, relating to Health and Safety.

Public services ombudsman final reports received during the relevant period were also reviewed.

Health and Safety Executive

The Sub-Committee received a presentation from a representative of another Health Board who had recently received a notification from the Health and Safety Executive (HSE).

The HSE had concluded that the Health Board had failed to act on previous absconding incidents, which would have better protected a 74 year old patient who absconded and later died following a fall and fatal injury, due to icy weather. The HSE had advised "Despite significant warnings, there was no risk assessment or physical security measures introduced to prevent vulnerable patients from leaving the ward unnoticed. This incident was easily preventable, and the risks should have been identified." Before Cardiff Magistrates' Court, the HB pleaded guilty to charges of breaching Section 3(1) and Section 33(1)(a) of the Health and Safety at Work etc. Act 1974 and were fined **£850,000** with full costs awarded of **£10,627.30**.

It was noted that previous incidents had occurred where wander-some patients had left the ward, and the internal Health Board investigation and that of the HSE was that insufficient actions had been taken in response to these incidents.

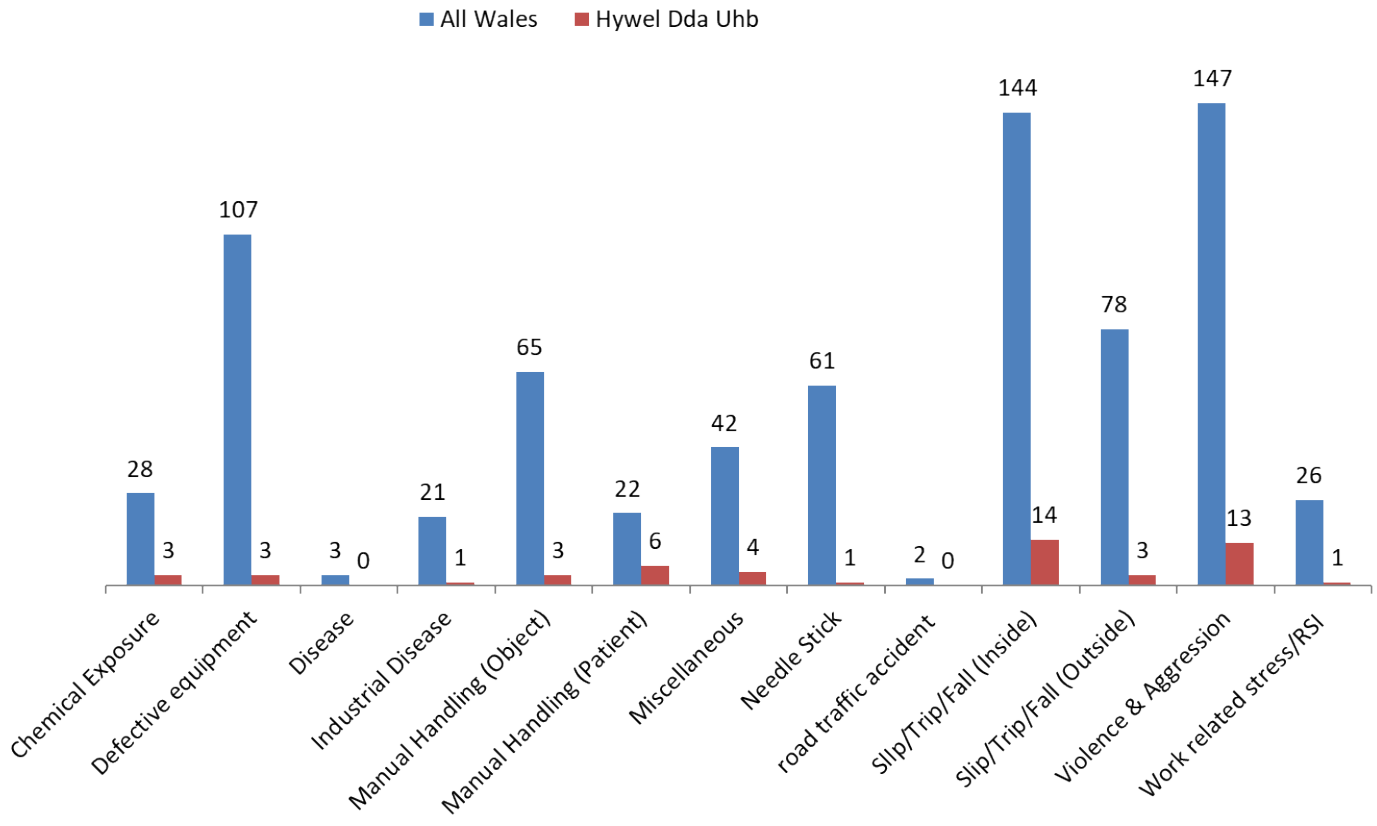
It was recommended to the Sub-Committee that Directorates within Hywel Dda University Health Board undertake a review of current security arrangements for clinical areas, prioritising areas where potentially confused or self-harming patients are being cared for. The review should include both physical and procedural arrangements. Access control locking systems are used in a number of clinical environments including the majority of Mental Health and Learning Disability wards, Emergency Departments, Maternity/Midwifery Lead Units and Child Health Wards. This would be taken forward by the Health and Safety Team and reported to the Health and Safety Committee.

Personal Injury Claims

The Chair welcomed Hannah Phillips, Legal and Risk Services, who provided a detailed presentation on personal injury related claims.

Slips, trips and falls was the most significant theme within the claims received by the Health Board.

The following graph depicts the open claims from 1/4/2020.



A number of case examples from Legal and Risk and also the local Claims Team were received, to highlight the common issues found in cases. Security issues in one case had raised concerns about the access to security on site and training of portering staff, who are often called upon to assist in situations. Actions had been taken at the time of incidents to address the lessons learnt. However, a concern was raised by the Sub-Committee about the increasing number of incidents and the vulnerability of staff particularly within A&E settings. This matter was also being discussed by the Health and Safety Committee.

Public Services Ombudsman Reports (PSOW)

Two final reports were received:

Case 14997 - Concerns were raised about the patient's wound management, nutrition and feeding, communication and care co-ordination. The care and co-ordination aspects of the concern had not been upheld by the Ombudsman; however, failings had been identified with feeding/nutrition and also record keeping around wound management. A number of actions were being taken forward by the service.

Case 19542 – The report highlighted failings in respect of communication with the family. The concerns raised about care and treatment & discharge arrangements were not upheld. The HB was required to apologise for the communication failures and issue a payment of £250.

For Information – Public Interest Report 202006310 (Not Hywel Dda case)
The case involving another Health Board related to a failure to identify a ruptured appendix. The Ombudsman found that there were two missed opportunities to identify and treat the appendicitis prior to the patient's death. A number of recommendations had been made, including review within ambulatory settings that appropriate arrangements were in place for the investigation of undiagnosed abdominal pain and reminder to clinical staff within these settings that a significant proportion of patients do not present with typical appendicitis. It was recommended that this report be shared with the Surgical Clinical Lead and Deputy Medical Director to ensure learning within the Health Board. This was supported by the Sub-Committee.

Risgiau:
Risks (include Reference to Risk Register reference):

There is a risk that patients may suffer harm and the Health Board be exposed to prosecution by the HSE if remedial action is not taken in response to absconding patients. However a review of incidents relating to absconding patients is being undertaken, to verify actions have been taken to address any lessons learnt to ensure prevention of further incidents.

Gwella Ansawdd:
Quality Improvement:

The identified actions for quality improvement from review of cases that remain on the Sub-Committee action log are as follows:

- Follow up, monitoring and action of all test results.
- Improvements in relation to communication.
- Medical records management and record keeping.
- Review of the discharge process.
- Issue an alert to the manufacture of the oximeter machine, due to two safety incidents.
- Ensure appropriate actions are being undertaken in response to any incidents involving absconding patients.

Argymhelliad:
Recommendation:

- Discuss whether the assurance and actions taken by the Sub-Committee to mitigate the risks are adequate.

Dyddiad y Cyfarfod Pwyllgor Nesaf:
Date of Next Sub- Committee Meeting:

14th December 2022