Enw'r Pwyllgor: Name of Sub-Committee:	Exception Report from Listening and Learning Sub-Committee
Cadeirydd y Pwyllgor: Chair of Sub-Committee:	Maria Battle, Hywel Dda University Health Board Chair
Cyfnod Adrodd: Reporting Period:	5th February 2021 and 3rd March 2021

Materion Ansawdd, Diogelwch a Phrofiad: Quality, Safety & Experience Matters:

The Sub-Committee reviewed 17 individual cases over the course of the two meetings in February and March 2021, across the spectrum of redress; complaints; claims; serious incidents, patient experience and Public Services Ombudsman reviews. The main issues arising from these cases and their associated actions are reported on an exception basis as follows:

Patient Experience Story

The Sub-Committee listened to a story from a patient who had been an in-patient for 6 weeks, awaiting transfer to Morriston Hospital for a cardiac procedure. The patient had been well and active prior to the admission. During this period, the patient suffered a general deterioration due to sleep deprivation and some nutritional concerns. Discussions were held regarding person-centred care and the concept of 'stealing the patient's time', alongside work on the 'virtual ward' that would have enabled monitoring of the patient whilst at home. A further update on this is scheduled for the Sub-Committee meeting in June 2021. The Sub-Committee agreed to request that this story be presented to the Senior Nurse Manager Team meeting, alongside further information from the Mental Health and Learning Disabilities Leadership Collaborative.

This story will also be included in a future Improving Experience Report for Board.

Assurance was also requested in relation to the cardiac pathway, which will be discussed with the Commissioning Team.

Inpatient Falls

As highlighted in the previous report to the Quality, Safety and Experience Assurance Committee (QSEAC), the Sub-Committee noted a continuing theme of inpatient falls. The thematic review is ongoing, and a meeting has been held with Lightfoot, who have agreed to assist with the improvement work involved.

Missed Fractures

The Sub-Committee noted the continuing theme of missed fractures. The 'Equip' Quality Improvement initiative has been established. An update is scheduled to be presented to the Sub-Committee meeting in May 2021.

Radiology Reporting

An update was provided by the Head of Radiology in respect of work progressing in relation to lessons learnt. Quality Governance meetings have been established to regularly review incidents, complaints, and claims. An Errors Discrepancy Group meet regularly, bringing together the four hospital sites to facilitate learning. There is ongoing work between Accident and Emergency and Trauma and Orthopaedics regarding the management of scaphoid injuries.

In relation to out of hours MRI provision, the service is currently operating between 7am-12 am, due to the fragility of the staffing position. As an additional measure, radiographers are being trained to undertake MRI images of lumbar spines.

The Sub-Committee agreed that the review of NICE guidance and clinical effectiveness standards would be extended to the Radiology department to consider opportunities for patient pathways.

A further update will be presented to the Sub-Committee meeting in September 2021.

Delay in Diagnosis

The Equip Project, reviewing the follow up and action of test results, has been delayed due to the pandemic. However, the Improvement Team is looking to reconvene at the earliest opportunity to progress the improvement project.

In relation to a delay in diagnosis of necrotising fasciitis, the Sub-Committee noted that a formal update on Sepsis 6 should be provided to QSEAC in the new financial year. With regards to the case discussed, the Sub-Committee agreed that the Scheduled Care Team would need to re-visit the expert findings and the proposed actions.

Moving and Handling

Learning across the Health Board is being promoted following an incident involving a patient, who suffered an injury whilst being moved, due to the position of the limbs not being checked prior to moving.

Mental Health Transformation

The Sub-Committee received a letter of feedback from the family of a patient regarding their experience during their daughter's episodes of mental health illness, including attendances at A&E, and during periods of crisis.

It had been identified that the complaint response had not appropriately recognised the family's distress and poor experience. One of the significant failings in the management of the complaint was the lost opportunity to meet and listen to the family's experience on receipt of the complaint. This is being addressed in the revised Complaint's procedure, in addition to

ensuring that letters fully empathise with the experience and impact on patients and their families/carers.

The Assurance plan was received, which would be monitored by the Mental Health and Learning Disabilities' Quality Governance Meeting. The issues raised by the family are being addressed by the Mental Health Transformation Programme, which include the establishment of 24 hour dedicated centres aimed at diverting patients away from A&E environments.

Public Services Ombudsman for Wales
Record Keeping

A final report received from the Public Services Ombudsman found that there were shortcomings in the standard of record keeping. This was discussed as a theme across the concerns and claims management agenda and would need to be escalated as a risk, both in relation to patient safety and effective management and security of records.

Four further final Ombudsman reports were noted, with recommendations made in relation to:

- Community referrals to the Community Mental Health Team (CMHT);
- Quality of initial screening and triage by the CMHT;
- Medication management and use of an unsuitable drug for an ischaemic stroke; and
- Review of the micturating cystourethrogram (MCUG) procedure following the birth of a baby at 33 weeks.

Speaking up Safely

An update on the Speaking Up Safely process was received. As part of the work to drive forward the culture of safe and compassionate care, the new process will encourage staff to discuss anything they may be concerned about in the work environment and feel safe in doing so. A very positive response had been received to the advertisement for Champion roles and training will commence during April/May 2021. Work on the new intranet page is also progressing.

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

The Sub-Committee highlights the continuing concerns regarding inpatient falls; missed fractures; and record keeping as discussed above.

Gwella Ansawdd:
Quality Improvement:

The actions for quality improvement have been identified as:

- Follow up and action of test results
- Reduction in the delayed diagnosis of fractures
- Review and audit of the WHO surgical checklist
- Reduction in inpatient falls

Argymhelliad:
Recommendation:

The Quality, Safety and Experience Assurance Committee is asked to discuss whether the actions taken by the Sub-Committee to mitigate the risks provide adequate assurance.

Dyddiad y Cyfarfod Pwyllgor Nesaf: **Date of Next Sub- Committee Meeting:**
7th April 2021