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:	2nd December 2020
Materion Ansawdd, Diogelwch a Phrofiad: Quality, Safety & Experience Matters:	

The Sub-Committee reviewed 9 individual cases across the spectrum of redress; complaints; claims; serious incidents and public services ombudsman reviews. The main issues arising from these cases and associated actions are reported on an exception basis as follows:

Claims and Redress

Inpatient Falls

Due to the number of cases being reviewed by the Sub-Committee involving inpatient falls resulting in harm, it was agreed to undertake a thematic review of all falls causative of harm and associated issues. This work would be undertaken in association with the falls scrutiny panels. The completed work would be presented to Quality, Safety and Experience Assurance Committee. Concern was raised by the Sub-Committee in regard to the volume of cases involving falls, which has previously been escalated to the Committee.

Neonatal Hip Referral Pathway

The case involved a delay in diagnosing and treating dysplasia of the hip following a breech birth, which resulted in long term implications for the infant. A service presentation was received on the neonatal hip referral pathway in place. Confirmation was received that there is a national audit in place. Members queried whether update/refresher training on newborn checks for doctors and midwives is in place. Confirmation was received that although midwives receive this training, there is no current arrangement in place for doctors. However, this is being taken forward and discussed on a national basis.

Never event – retained dressing in wound

Following attendance at Minor Injuries Unit (MIU) for treatment for a wound, it was identified that some aquacel dressing had been left within a patient's wound in error. Following multiple attempts to recall the patient, the patient attended a few days later and received appropriate treatment and antibiotic therapy. In addition to departmental learning, action plans include planned work on referral pathways, from MIU to relevant stakeholders, and publicity to make the general public aware of conditions that can be safely dealt with by a GP-led MIU.

Public Services Ombudsman for Wales

Delay in diagnosis and treatment

The Sub-Committee noted two Ombudsman final reports relating to the Health Board, which had been received since the previous meeting. The findings of the first report related to a delay in diagnosing a leak in the patient's bowel following surgery undertaken 9 days prior. The Ombudsman found that a CT scan should have been undertaken earlier. The patient's discharge from the surgical procedure, whilst not unsafe, may have been premature. There was no discharge summary or evidence of the patient being given post-surgical management on discharge. Recommendations made by the Ombudsman included reminding all staff of the NICE guidance on risk assessments and extended medication prescriptions for cancer surgery patients at risk of developing blood clots. There was a further recommendation to remind staff of the importance of completing a discharge summary, and the importance of the nature of the conversation held with patients before leaving hospital, ensuring the appropriate advice is provided.

Communication and engagement with family

The second Ombudsman final report involved the transfer of an elderly patient under section to a mental health ward. The family disputed the need for transfer. It was concluded that the transfer was appropriate, however evidence of communication with the family was lacking and a review meeting should have been held earlier with the family to discuss the patient's behaviour and the rationale for transfer. Recommendations from the Ombudsman are that the Health Board prepares guidance for families on the different, but overlapping, purposes of the Mental Capacity Act (MCA) and the Mental Health Act (MHA) and when it would be appropriate for an Independent Mental Capacity Advocate (IMCA) to be present during an assessment. There was a further recommendation that a mechanism be introduced whereby if a family member is unhappy about a decision for admission under the MHA, even if agreed by the nearest relative, there is an option for a broader family group meeting to be held, time permitting.

Both action plans to meet the recommendations are progressing across the Health Board and no concerns were raised regarding compliance with timescales.

Complaints

All 3 cases reviewed involved a delay in diagnosis. The first case due to an incorrect CT scan report; the second relating to a failure to escalate to an appropriate Consultant; and the third, a primary care case regarding failure to refer the patient to an Unscheduled Care (USC) clinic in a timely manner, in line with the appropriate guidance, which is being reviewed and taken forward by the practice. The 2 Health Board cases have been deferred for further evidence of learning assurance.

The Sub-Committee has planned further discussion with the Head of Radiology and Clinical Lead in respect of the themes emerging through the review of cases regarding radiology services.

Risgiau:

Risks (include Reference to Risk Register reference):
The Sub-Committee highlights the continuing concerns regarding inpatient falls. A thematic review is being undertaken which will be presented to the Committee on completion.
Gwella Ansawdd: **Quality Improvement:**
The identified actions for quality improvement are: • Follow up and action of test results • Reduction in the delayed diagnosis of fractures • Review and audit of the World Health Organisation (WHO) surgical checklist • Referral process and management of patients requiring specialist services • Process for management of patients presenting with Head and Neck Pain to the Emergency Department • Reduction in inpatient falls
Argymhelliad: **Recommendation:**
• The Quality, Safety and Experience Assurance Committee is asked to 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:**
3rd February 2021