Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Enw'r Pwyllgor: Name of Sub-Committee:	Exception Report from Listening and Learning Sub-Committee
Cadeirydd y Pwyllgor: Chair of Sub-Committee:	Maria Battle, Health Board Chair
Cyfnod Adrodd: Reporting Period:	May 2021

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

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

Patient Experience Story

The Sub-Committee received a story from a patient who had suffered an accident, which resulted in a state of paralysis. The patient described his experience following his accident, and the way in which he was initially treated and transported to A&E by ambulance, and his later experience at A&E and the transition to the (Intensive Treatment Unit) ITU and on to the ward. A theme of not paying attention to the needs of the patient was paramount throughout. The patient described a lack of co-ordination and consistency, which caused fear and doubt when feeling vulnerable. A perception of a part time health service over a weekend had also been raised. The patient had been given the opportunity of talking to the preceding Deputy Chief Executive Officer (CEO), which the patient valued and felt heard. Themes within the story related to patient engagement, listening to the patient, paying attention to issues that matter to the patient, and keeping the patient informed throughout their journey.

The case file would be reviewed by the Clinical Lead for Orthopaedics to enable further review of the management of care and treatment and provide assurance around learning from events.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

A number of cases over the course of the previous few months had been shared with the Sub-Committee regarding the failure to appropriately communicate with patients and their families regarding DNACPR decisions. The matter had been referred to the Resuscitation-Recognition and Response to Acute Illness Learning Set (RRAILS) Group for consideration of awareness raising and producing good practice guidance for staff. A meeting to progress this piece of work has been arranged with the relevant staff.

Radiology Reporting

Further to the Sub-Committee report presented to Committee in April 2021, a continuing theme of reviewed cases related to the standard of radiology reporting. An update would be provided to the Sub-Committee by the Head of Radiology in respect of Quality Governance arrangements and lessons learnt in September 2021. In the interim, assurance would be sought regarding the red flagging system and alerts for incidental findings.

Delay in diagnosis

A lack of follow up, or action of test results and referrals, continued to be a theme within root cause analyses of incidents and complaints. The 'Equip' Quality Improvement project reviewing this area of required improvement will report back to the Sub-Committee in July 2021.

Public Services Ombudsman for Wales (PSOW)

Mental Health Services

A final report received from the Public Services Ombudsman in relation to a patient's mental health treatment found that:

- Communication with the patient regarding assessment and medication withdrawal was lacking;
- There was a lack of Occupational Therapy (OT) support during the admission to the Unit;
- There was a failure to arrange ongoing support and therapeutic interventions on discharge;
- There was a delay in the patient receiving a series of assessments and review.

Recommendations made by the PSOW required the Health Board to:

- Provide a full and sincere apology.
- Take the matter to the Mental Health and Learning Disabilities Directorate's Medical Staffing Committee. The Committee should remind all medical staff of the necessity to be aware of patients' concerns, respond to them, and note the action. This should be undertaken in association with the Health Board's Mental Health Quality Assurance Team.
- Review the referrals made for the patient to ensure that they have been followed up and appointments made, where possible, if outstanding.
- Review the referral processes by undertaking a learning exercise to identify what happened in the patient's case and change the process to avoid repetition, if required.
- Ensure the OT service develops auditable assessment processes, with targets, to ensure initial assessments and assessments post-discharge are completed in a timely fashion.
- Ensure OTs at the Unit receive training/supervision in assessment and treatment planning. Further consideration is given to adopting a standardised assessment tool for initial assessments e.g. Model of Human Occupation Screening Tool (MOHOST).

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

The Sub-Committee highlights the continuing concerns regarding inpatient falls; missed fractures; radiology reporting; and record keeping/management of records.

Gwella Ansawdd:
Quality Improvement:

The identified 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 World Health Organisation (WHO) surgical checklist
- Reduction in inpatient falls
- Improvements in relation to communication and compliance with the DNACPR policy

Argymhelliad: **Recommendation:**
The Quality, Safety and Experience Assurance Committee is requested 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:**
2nd June 2021