

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 2021
Materion Ansawdd, Diogelwch a Phrofiad: Quality, Safety & Experience Matters:	

The Sub-Committee reviewed a number of presentations and individual cases from across the concerns agenda and public services ombudsman investigations.

February 2022 Meeting

The main theme of the meeting was mental health services.

Incident – HD86894/HD86631

The Sub-Committee reviewed the findings of an investigation report related to both dental services and mental health services. The review findings had shown appropriate care and treatment had been provided and that reassurance had been given in light of the patient's ongoing dental concerns. The Sub-Committee received assurance against the action plan to meet the recommendations made in the review report.

A discussion took place at the meeting about the importance of training for all staff in situations where distressing and vexatious calls were received and ensuring that appropriate steps were taken including referrals to the appropriate services. The need to upskill all staff to use the appropriate alert systems was required.

The Sub-Committee discussed the need for improved coordination between various services involved where a patient is distressed and making a variety of contacts into the organisation. It was therefore difficult to monitor the frequency and intensity of the contacts to take appropriate action. The current systems made it very difficult to identify the root cause of the distress.

Whilst there were arrangements in place for complex case management it was agreed that systems should be developed to identify when a caller approaches numerous services, resulting in the situation escalating so that the appropriate support could be provided for both the caller and the staff involved. One of these risks noted that the current telephone system had a lack of recording ability and facility to identify repetitive calls, often resulting in the caller leaving messages on individual answer phones. Each department storing their own medical records and there not being access to one complete set of records for each patient also presented a risk to identifying issues for the patient and in respect to duty of candour/ disclosure responsibilities.

Patient Experience

The Sub-Committee received a presentation on the work to improve the capture of patient experience feedback within mental health services. The barriers were recognised, particularly the challenges when a patient is detained under the Mental Health Act. There were a number of ways in which patients were encouraged to provide feedback, a QR code was available, this could be accessed from iPads and mobile phones; however there was limited feedback provided, to date. The information was also compared with other sources of feedback from healthy ward checks, complaints, compliments and incidents. There were often professional barriers in patients speaking up and therefore advocacy was also in place. Members were also advised of the patient / carer voice through co-production and through third sector organisations such as West Wales Action For Mental Health (WWAMH). The current transition to a new patient experience system (Civica) would support this work and provide additional ways to provide feedback across secondary and community mental health services.

Legal Cases (Mental Health)

The Sub-Committee receive an update on ongoing inquests, claims and Court of Protection Cases. In discussing mental capacity related cases the importance of ensuring that the best interest position was being applied correctly was highlighted, ensuring an appropriate authorised person is being contacted to make such decisions.

Considerations were also made in respect of part funding placements. The recent cases had highlighted that with part funding came shared responsibilities for every aspect of the patient's welfare, and care and legal framework responsibilities. In terms of recently reviewed cases there had been no requirement on the HB to part fund.

A letter had been received from the Welsh Risk Pool (WRP) reinforcing the 60 day deadline for submission of the claims learning from events reports. Members were advised of the challenges in obtaining information on service improvements and lessons learnt during such challenging times, particularly in areas with a high level of absence and service pressures. Some staff were vulnerable and finding it difficult to engage in conversations particularly around Putting Things Right (PTR) and inquests.

March 2022 Meeting

Complaint - The Sub-Committee reviewed the case of a young person with hearing loss who had attended the audiology department for an outpatient appointment. The member of staff who had been liaising with the patient in the waiting room area had not been made aware that the patient was profoundly deaf and a concern was received about the manner in which the patient was addressed by the member of staff. The Sub-Committee noted the work undertaken by the department to avoid a further incident occurring. This included the audiology service informing reception and COVID screening staff of any patient specific needs in advance. British Sign Language charts had been provided, with a range of greetings, COVID screening questions and other key words. These cards had also been translated into Welsh. The sub-committee has asked for the good practice in this case to be shared across all reception areas across sites and in outpatient settings.

Public Services Ombudsman Reports

Two final (non-public interest) reports were received by the Sub-Committee. These reports had not been upheld by the Ombudsman's office, who had found that the care and treatment had been appropriate in both cases.

A case summary of an early settlement had been received. The case related to scheduled care, Surgery. The Ombudsman found that the offer of private care and the decision to end the doctor-patient relationship did not comply with professional guidelines. Due to the Consultant ending the doctor-patient relationship, the patient had been left without care because she had wanted to complain.

The actions required had been undertaken, including a reminder being issued to all consultants of the professional guidelines for private practice and not to discuss private care in NHS consultations. A review of the guidance in light of the ombudsman's findings had been undertaken.

Risgiau:

Risks (include Reference to Risk Register reference):

Ensuring the best interest decision making process is appropriately applied for patients who lack capacity; and ongoing commissioning arrangements carefully consider monitoring and assurance arrangements for all funded placements and whether part-funding is required.

Medical records management and storage, including the completion of patient records in line with professional standards;

Ensuring all staff comply with professional guidance on the Health Board procedures for undertaking private practice.

Gwella Ansawdd:

Quality Improvement:

The identified actions for quality improvement from review of cases have been identified as:

- Follow up, monitoring and action of all test results.
- Improvements in relation to communication.
- Medical records management and record keeping.

Argymhelliad:

Recommendation:

For QSEC 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:

4th May 2022

**PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 April 2022
TEITL YR ADRODDIAD: TITLE OF REPORT:	Listening and Learning Sub-Committee (LLSC) Annual Report 2021/22
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Paul Newman, LLSC Chair
SWYDDOG ADRODD: REPORTING OFFICER:	Louise O'Connor, Assistant Director (Legal Services/Patient Experience)

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The purpose of this paper is to present the Listening and Learning Sub-Committee Annual Report 2021/22 to the Quality, Safety & Experience Committee. The Sub-Committee Annual Report provides assurances in respect of the work that has been undertaken during 2021/22 and outlines the main achievements which have contributed to robust integrated governance across the University Health Board (UHB).

Cefndir / Background

The UHB's Standing Orders and the Terms of Reference for the Listening and Learning Sub-Committee require the submission of an Annual Report to the Quality, Safety & Experience Committee to summarise the work of the Sub-Committee and to identify how it has fulfilled the duties required of it.

The fundamental purpose of the Sub-Committee is to provide clinical teams across the Health Board with a forum to share and scrutinise learning from concerns and to share innovation and good practice. The Sub-Committee will also provide a forum to promote changes and innovations to service delivery and ensure that best practice is shared and areas of concern are highlighted and communicated to the responsible officer or Board Committee/Working Group. Through identifying learning points and changes to practice evolving from investigation and review of concerns and patient experiences, the Sub-Committee will identify themes and trends, providing assurance that robust management plans are in place for current and emerging clinical risks.

The Listening and Learning Sub-Committee Annual Report specifically comments on the key issues considered by the Sub-Committee in terms of assurance around lessons learnt.

Asesiad / Assessment

The Listening and Learning Sub-Committee has been established under Board delegation with the Health Board approving terms of reference for the Quality, Safety & Experience Committee its Board meeting on 28th May 2020.

The terms of reference were reviewed by the Listening and Learning Sub-Committee at its meeting on 1st December 2022 and approved by Quality, Safety and Experience Committee on 8th February 2022.

These terms of reference clearly detail the Sub-Committee's purpose to provide assurance to the Quality, Safety & Experience Committee around the organisation's management of learning from events from significant events, and identification and escalation of risk.

In discharging this role, the Sub-Committee is required to oversee and monitor the Concerns Management and Learning from Events agenda for the Quality, Safety & Experience Committee in respect of its provision of advice to the Board, and ensure implementation of the agenda against the following areas of responsibility:

- Learning from the investigation of concerns (incidents, complaints and claims, health and safety incidents) is shared with, and communicated with, clinical teams across the Health Board.
- Patient experience informs the evaluation of known or emerging concerns or challenges with clinical services, and solutions to improve the quality and safety of the services provided by the Health Board.
- Provide a safe and open forum for peer review and support for the investigation processes, and recommendations or learning arising from this work.
- Identify themes and trends from feedback, external reviews, and through other patient experience mechanisms such as surveys and patient stories.
- Request 'deep dive' reviews into any areas of concern highlighted by the review of emerging themes/trends. Escalate any immediate areas of concern to the relevant Group/Committee or senior staff, as appropriate.
- Consider actions that have been, or are proposed to be, implemented following investigations into concerns and consider where actions can be shared with other services to ensure that best practice and improvements to the quality and safety of patients and learning is disseminated across the Health Board.

The Listening and Learning Sub-Committee Annual Report 2021/22 is intended to outline how the Sub-Committee has complied with the duties delegated by the Quality, Safety & Experience Committee through the terms of reference set, and to identify key actions that have been taken to address issues within the Sub-Committee's remit.

Constitution

From the terms of reference approved on 1st December 2021, the membership of the Sub-Committee was agreed as the following. Since this date two additional members have been included, the clinical lead for clinical effectiveness and clinical lead for mortality reviews:

- Independent Member (Chair)
- Deputy Medical Director (Acute Services)
- Associate Medical Director (Primary Care & Community)
- Associate Medical Director (Quality and Safety)
- Clinical Lead (Clinical Effectiveness)
- Clinical Lead (Mortality Reviews)
- Assistant Director (Legal Services/Patient Experience) (Lead Officer)

- Assistant Director of Nursing (Quality Improvement/Service Transformation)
- Assistant Director of Nursing (Operational Nursing & Quality Acute Services)
- Clinical Director, Therapies
- Assistant Director of Therapies and Health Science
- Senior Member Triumvirate Team (all directorates) & Link to Quality/Governance meetings
- Head of Quality & Governance
- Head of Complaints and Resolution Management
- Head of Legal Services/Solicitor (or Deputy)
- Head of Patient Experience
- Head of Health, Safety & Security
- Head of Culture and Workforce Experience
- Clinical Effectiveness Manager
- Service representatives – invited according to agenda
- Workforce & OD – Relationship Management Team
- Clinical Leads (appropriate agenda items)
- Head of Engagement and Transformation

Meetings

Sub-Committee meetings have been held on the following dates and all were quorate as follows:

- 7th April 2021
- 5th May 2021
- 2nd June 2021
- 7th July 2021
- 1st December 2021
- 2nd February 2022
- 9th March 2022

No meetings were held between 7th July and 1st December 2021 due to operational and capacity pressures associated with the COVID-19 Pandemic.

The terms of reference were revised in December 2021 and the meetings are now held on a bi-monthly basis.

As the Listening and Learning Sub-Committee is directly accountable to the Quality, Safety & Experience Committee for its performance, assurance has been provided to the Committee through a formal written update report following each meeting, which is received at the subsequent Committee meeting.

Sub-Committee Terms of Reference and Principal Duties

In discharging its duties, the Listening and Learning Sub-Committee has undertaken work during 2021/22 against the following areas of responsibility in relation to its terms of reference:

- **Forum to scrutinise and share learning across the Health Board**
During 2021/22, the Sub-Committee has reviewed individual cases across the spectrum of complaints, redress, patient experience, claims, incidents, inquests and external reports including Public Services Ombudsman reports.

The sub-committee has also begun to theme the meetings to enable a deep dive into themes and specific areas, with representation from the relevant service areas.

- **Promote changes, innovations and share best practice**

The Sub-Committee has identified a number of common themes following review of the cases, which have resulted in deep dives/quality improvement initiatives being initiated to address the learning in these areas. Themes include:

- Delays/Missed Diagnosis due to failure to act on test results
- Missed diagnosis of fractures
- Compliance with the best interest process for people who lack capacity to make decisions
- Communication issues
- DNACPR decisions and communication with families
- Discharge planning
- Provision of reasonable adjustments for people attending hospital with learning difficulties
- Radiology reporting, including delays

Findings from external reviews on patient experience have been shared to inform best practice and national publications on themes and trends across Wales, including those from the Welsh Risk Pool and Legal and Risk Services.

Any issues requiring escalation have also been referred to the appropriate Lead Officer, Sub-Committee, or Committee as appropriate.

Key Risks and Issues/Matters of Concern

During 2021/22, the following key risks and issues/matters of concern were raised at the Quality, Safety & Experience Committee:

- Record keeping and records management – concerns were raised in relation to the quality of the clinical entries and standard of documentation; and storage of the records with various departments holding their own records. This caused risks for patient safety as well as legal risks associated with non-disclosure.
- Follow up and action of test results, which had been a continuous theme from the previous year. A quality improvement initiative is ongoing to identify solutions.
- Call monitoring from patients and triangulation of information to identify escalating situations.
- Compliance with best interest process for patients who lack capacity
- Learning from Court of Protection Cases regarding visual monitoring in the community

Sub-Committee Developments for 2022/23

The Sub-Committee will seek to strengthen the triangulation of data and will set up an Engagement and Experience Sub-Group to review and analyse feedback received across the organisation via engagement, diversity and inclusion, staff and patient experience, as well as speaking up safely, compliments and complaints, to inform the Health Boards decision making and learning from events process.

Improving Reporting on the patient experience and concerns key performance indicators will be incorporated into the performance framework.

Argymhelliad / Recommendation

To endorse the Listening and Learning Sub-Committee Annual Report 2021/22.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an annual report within six weeks of the end of the financial year.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability

Effaith/Impact:

Ariannol / Financial: Ansawdd / Patient Care: Gweithlu / Workforce: Risg / Risk: Cyfreithiol / Legal: Enw Da / Reputational: Gyfrinachedd / Privacy: Cydraddoldeb / Equality:	Included within the report, where appropriate.
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