Enw'r Pwyllgor: Name of Sub-Committee:	Listening and Learning Sub-Committee Exception Report
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 December 2022 and received a number of presentations and individual cases from across the Concerns and Safeguarding Portfolio, relating to palliative care.

Final reports received from the Public Services Ombudsman during the relevant period were also reviewed.

Engagement and Experience Working Group

The terms of reference for the Sub-Committee's Working Group on Engagement and Experience were received and approved.

The Working Group will triangulate feedback received via engagement, equality and diversity, patient experience and staff experience. The Group will also consider how the Listening and Learning Sub-Committee uses the data to provide accurate and helpful information to the Health Board and to the public. The design and oversight of a process for the approval and use of patient experience related surveys will also be a key function of the Group.

Patient Experience

An emotive story was heard by the Sub-Committee relating to a patient and family experience during the patient's end of life. The family provided positive feedback about the care and support provided by the Palliative Care Team. However, the family also felt that the end of life support was not managed well and timely support was not available.

It was recognised that service user feedback was difficult to capture in this area due to the sensitive nature of the experience. An all Wales palliative care service user feedback group is being established, looking at bereavement and palliative support due to the variance in services across health boards.

A national palliative care feedback survey would be undertaken during the first quarter of 2023. This will be undertaken using an iteration of the Civica Service User system, which will be the first system of its kind.

Within Hywel Dda surveys are undertaken within community nursing; capture elements of palliative care and end of life care. Previously these surveys were predominantly undertaken within Pembrokeshire but are now being replicated across other areas of the Health Board.

In response to a question about how information was shared with the services involved, it was explained that the system was designed for the services to access at any time and obtain real

time data. There is ongoing training to ensure that within each service there are a number of staff who can access the information and use it to produce reports, posters and. 'Push' reports were also being generated so that an email summary report can be provided to the relevant service leads on a regular basis. Information has also been included in the reports presented to the Quality Governance Directorate meetings.

Complaints and Incidents
Two complaints were reviewed which highlighted the importance of awareness within the specialist palliative care team and ensuring earlier communication/referral from medical/surgical teams.

Issues regarding communication and the patients' understanding of information provided were also highlighted in the communication. Support following diagnosis was important by both primary and secondary care.

Two incidents were reviewed which related to palliative patients managed in the community setting. In both cases there was a delay in resourcing an ambulance to attend to the patients due to service delivery challenges: the number of ambulance units on the road already or allocated to attend higher or the same type of call; delayed handovers. The review into Case 2 also noted that there was a reduced number of vehicles available at that time (less than the expected number) which would have also had an impact on the ability to respond to the call.

Public Services Ombudsman Wales (PSOW)
Four cases that had been referred to the Ombudsman were reviewed.

Case 18270 related to the alleged failure to diagnose a pulmonary embolism, together with care and treatment concerns. The case had been investigated and upheld in respect of post surgical support. Several recommendations had been made including key worker guidance. The actions were being progressed.

Case 21473 related to DNACPR, and the lack of involvement of the palliative care team. This case had not been upheld by the Ombudsman, however, issues were noted in respect to expectations and communication.

Case 796 related to access to a palliative care clinical nursing service, communication and understanding of the term palliative care and link to end of life care. This was currently subject to investigation and the final report would be reviewed by the Sub-Committee.

20704 this case was also subject to investigation but related to communication regarding the treatment pathway, referral into palliative care services, and access to specialist services. Concerns were also noted in respect of treatment options, medication and nutrition. The investigation report in this case would be reviewed by the Sub-Committee Immediate actions were being undertaken following the complaint investigation, including relevant staff attending a medication safety course and reflection by the oncology and cancer teams.

The Sub-Group spent time discussing the importance of communication and patient information, ensuring information was accessible and meaningful. Communication training on empathy and breaking bad news also needed further consideration.

The Sub-Committee agreed to hold a second meeting on the theme of palliative care and bereavement services. A discussion on the Palliative Care Strategy and the new all Wales Bereavement Pathway would be undertaken with the lead officers.

Themes identified included:

- Communication and links to Specialist Palliative Care Team
- Specialist Palliative Care Team criteria and awareness raising
- Communication to patients about the provision of services, in particular the relationship between Swansea Bay University Health Board Specialist Oncology Service
- Patient support, involvement and understanding of their treatment plan
- Pre and post treatment surgical support
- Perceived delay in diagnosis and commencing cancer treatment
- A Regional Collaboration for Health (ARCH) review of the cancer pathways
- Support in receiving diagnosis and the communication aspects of breaking bad news
- Language line support and patient information

For Information – Public Interest Report 202102604 (Not Hywel Dda case)
The case highlighted the importance of the Health Board's responsibilities for commissioned care. The service involved was neurology. The Ombudsman upheld that there was a delay in diagnosis. This would be circulated for information as learning was applicable across all health boards.

Public Services Ombudsman – Published Data
The all Wales data in respect of the Public Services Ombudsman case was received. It was noted that the report was difficult to interpret without narrative. Key observations for Hywel Dda included:

- HDdUHB was among the Health Boards with the lowest number of referrals to PSOW (5% of complaints were referred)
- There was a need to improve timeliness of complaint investigations
- There was a high number of early resolutions indicating the Health Board's willingness to address issues early
- Whilst there was a higher number of upheld cases – this amounted to 6 cases and should be taken in the context of the lower number of referrals.

It was agreed that a 'look back' exercise would be undertaken to ensure that actions were still being monitored and were having an impact on the lessons learned.

Complaints Handling Toolkit
The Sub-Committee received the revised Complaints Handling Toolkit to drive improvement in the quality and accuracy of the complaints investigations and to improve on the timeliness. It is anticipated that the process would deliver a more person-centred approach for both staff and patients with a strong focus on accountabilities and responsibilities. New performance indicators for performance and complainant experience had been developed. Work was ongoing with the 'Improving Together' Programme to ensure that concerns and the revised Key Performance Indicators (KPIs) were being captured as part of the safety and performance dashboards.

Risgiau:

Risks (include Reference to Risk Register reference):
Further discussion on risks will take place with the service team at the next meeting to discuss the themes highlighted above.
Gwella Ansawdd: **Quality Improvement:**
The identified actions for quality improvement from the 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:**
The Quality, Safety and Experience Committee is asked to receive assurance from the content of the LLSC Update Report.
Dyddiad y Cyfarfod Pwyllgor Nesaf: **Date of Next Sub-Committee Meeting:**
8 March 2023 (focusing on communication)