GIG CYMRU NHS WALES | 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:	Paul Newman, Chair
Cyfnod Adrodd: Reporting Period:	August 2022

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

The Sub-Committee reviewed a number of presentations and individual cases from across the concerns and safeguarding portfolio, relating to Women and Children's Services.

The Public services ombudsman final reports received during the relevant period were also reviewed.

Clinical Negligence Claims

The Sub-Committee received a presentation from Legal and Risk Services regarding clinical negligence claims.

From January 2020 to date, 16 claims had been settled relating to Women and Children's services, 4 of these were high value claims requiring Welsh Government review.

There were 50 cases open to investigation, 8 relating to gynaecology; 6 midwifery; 5 paediatric services; 17 obstetric cases; 14 of these were high value claims (2 paediatric, 11 obstetric and 1 midwifery).

Examples of the types of injuries suffered were explained as follows:

Baby	Mum
Hypoxic brain injury	Maternal tears
Shoulder Dystocia/Erbs Palsy	
Forceps injury	Wrongful birth
Stillbirth	Suturing errors
Hip Dysplasia	Psychiatric injury
Fractures during delivery	Injuries to organs during C-section
Cuts/other marks during instrumental delivery	Pre-eclampsia misdiagnosis

In respect of the themes within breaches of duty of care, these included:

- Cardiotocography (CTG)traces – incorrectly interpreted
- Foetal distress – failure to identify
- Failed instrumental delivery causing delay in initiating Emergency Caesarean Section

- Failure to summon senior medical and/or senior assistance.

Two redress cases were also received in respect of injuries sustained by failing to reposition an oximeter probe, these were being managed as part of the redress process including a review of actions undertaken, further training and raising risk awareness. It was also agreed to issue an alert to the manufacturer. This matter would be reviewed by the Sub-Committee in September.

A Claim was reviewed which, following expert opinion, identified post-natal breaches of duty, including a failure to monitor urine output; failure to restrict fluids and recognise fluid overload; and failure to escalate to a senior obstetrician. Discussion took place about the importance of clarifying the definition of senior clinician in the case. The Sub-Committee received assurance that the service had implemented a detailed action plan and had raised awareness of the issues in the case to all relevant staff via the maternity newsletter.

The Chair advised that the national trajectory for claims was worrying and unsustainable. This was recognised by all and the importance of education and addressing some of the wider implications which often presented barriers to the successful defending of a case, such as poor record keeping and management needed to be addressed.

The Sub-Committee held a lengthy discussion on the actions being undertaken to address the common themes in claims within women and children's services and involvement in work that was taking place nationally.

In respect of CTG's, the Sub-Committee noted that the Health Board had a system installed to undertake two types of monitoring as well as Central monitoring. The CTGs were electronically captured which also allowed the clinical team to annotate when a live event has taken place.

The team described the robust process in place for monitoring incidents and near misses. A full review of incidents were being undertaken involving potential harm. A weekly multi-disciplinary (MDT) team meeting reviews all reported cases and a senior MDT provided oversight of lessons learnt and approval of actions plans.

The Sub-Committee received assurance from the Head of Midwifery and the wider Directorate around the processes for managing clinical risk, learning from events and concerns management processes. The arrangements for sharing and learning from good practice were also discussed.

Patient Experience

A presentation by Mr A Treharne, Consultant shared a very powerful patient story about the experience of a patient who had suffered a known complication of surgery. The patient then received misinformation and a poor standard of communication from a different clinical team about the initial surgery and harm caused. The impact of this had left the patient very distressed and fearful, which could have been avoided had the correct communication taken place. There had also been a negative impact on the staff involved who were frustrated due to incorrect information being provided and the impact of this on the relationship with the patient who needed a great deal of support and reassurance as part of ongoing pathways of care. The case highlighted important issues of managing shared care across sites and ensuring continuity for the patient.

The story would be shared widely across the organisation and would be incorporated into concerns and duty of candour training, as well as shared with the Workforce and Organisational Development team responsible for delivering the improving experience training across the organisation.

Incidents

The Sub-Committee received a report summary of two incident cases highlighting the importance of effective communication following a serious incident.

The cases identified that whilst initial communication had taken place with the mother and family, ongoing communication was not as robust or as frequent as it should have been. Consideration was given to the pending new legal duty of candour. The importance and significance of the new legal duty was recognised as well as the challenges that would be felt, particularly in relation to moderate harm incidents.

The Sub-Committee noted the concern that one of the barriers related to the cultural fear around risk reporting and the process and that this would need to be addressed as part of the new duty of candour training.

Complaints

The first case involved a patient who had been discharged before a surgical opinion had been sought. Appropriate pain relief had been provided and on this basis there was no qualifying liability identified. There had also been an error in transfer with the wrong hospital being noted by the tertiary centre. The Sub-Committee noted that reflective practice had been undertaken and the communication issues on transfer were being managed through training.

The second case identified a missed opportunity for discussion between obstetrics and the diabetes teams which could have enabled a multi-disciplinary review, ensuring blood pressure and diabetes were being managed appropriately in the patient throughout pregnancy. There was a need to establish direct communication between obstetric and renal teams at consultant level. The Sub-Committee requested that a learning assurance plan be received for the next meeting.

Public Services Ombudsman Reports (PSOW)

Four final (non-public interest) reports were received and noted. These were unrelated to women and children's services:

Case 14792 related to a delay in diagnosis, involving GP and cancer services. The Sub-Committee noted that actions were progressing within timescales.
Case 15634 was a historic case involving a delay in diagnosis liver cancer. The Sub-Committee noted that actions were progressing within timescales.
Case 17027 related to a trauma and orthopaedic, shoulder injury case. The actions had been completed and submitted to the PSOW. It was noted that the complainant was not satisfied with the outcome of the PSOW investigation. Further contact was awaited from PSOW.

The Final Report for **Case 19426** did not uphold the complaint, but learning was identified regarding communication and management of atrial arrythmia. This was being taken forward by the Department and medical teaching session would be provided in September 2022 to take forward the learning.

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

Risk of further harm identified following second incident associated with lack of repositioning of the oximeter. The Directorate nurse who was updating previous action plans and training/education on an urgent basis was managing this.

Gwella Ansawdd:
Quality Improvement:

The identified actions for quality improvement from 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

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:

7th September 2022