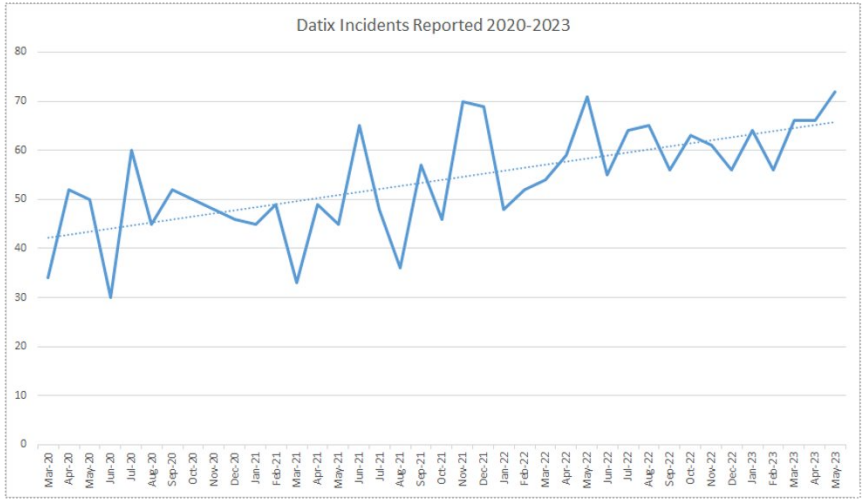
Initial response to Neonatal findings relating to the Thirwall Enquiry

Clinicians' safety concerns and speaking up



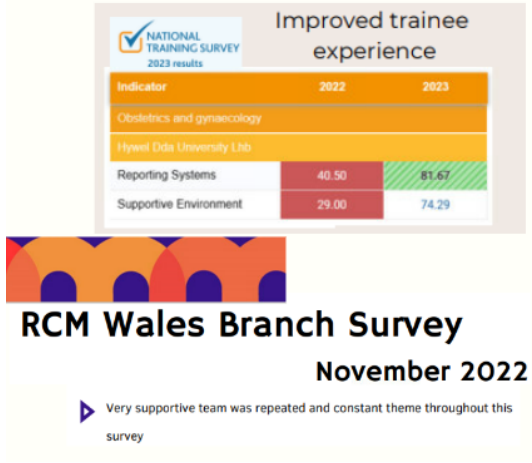
Improved Evidence of Psychological Safety

40% increase in incident reporting without an increase in the number of adverse events

Improved staff well-being

Improved National Training Survey conducted by the General Medical Council particularly in relation to reporting systems and supportive environment

Improvements noted in RCM Wales Branch Survey



4 Improved staff well-being

A Royal College of Midwives survey and a Health Education Improvement Wales Survey both identified significant improvement of staff experience. Staff reported an improvement to workplace culture and generally felt more confident to escalate

Implementation of the Hywel Dda University Health Board **"Speak Up Safely Scheme"**

Clinicians' safety concerns and speaking up

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Collaborative working across Maternity and Neonatal Service

Winner HDUHB – MDT Maternity & Neonatal Risk and Governance Team

Changing Workplace Culture around Adverse Events in Maternity and Neonatal Care

Positive Learning Culture and Review of Adverse events in Hywel Dda University Health Board recognised by the Maternity Neonatal Safety Support Programme as a "Bright Spot"

Encouraging an open and honest reporting culture

Clinical Incident Trigger List **MUST REPORT** for SCBU

Delivery	• Unexpected death • Cardiac/respiratory arrest • Call / failure/delay to respond • Child abduction • Serious infection • Missed diagnosis • Treatment/procedure error • Unavailability of appropriate health care professional • Delayed diagnosis & treatment • Cancelled treatment/surgery • Delayed discharge • Lack of suitably trained staff • Failure To Follow Protocol/Process • Accident or injury to patients/staff/visitors	• Unexpected admission (Any baby 37 weeks or more) • Re-admission to hospital from community • Infiltration/Extravasation injury • Medication Error – administration/prescribing error/delay 30 minutes for 4-6 hourly medication 1 hour for 8-12 hourly • Complications relating to Feeding i.e. aspiration • Unexpected complication • Unexpected readmission • Failure to access /act on results • Unsafe/inappropriate clinical environment • Self-harm/self-abuse • Pressure ulcers • Discharge against medical advice
Organisational	• Equipment issue/operational error • Contact/exposure to infection e.g. MRSA • Breach of Confidentiality • Laboratory error • Communication issues between and outside team • Documentation Issues eg unavailability of patient notes, illegible or lack of documentation, Patient ID • Consent (inadequate , poorly documented or no consent for procedure)	• Violence or verbal abuse • Ward Closure (Black) • Extreme patient acuity • Drug related eg mislabelling/missing • Inappropriate admission (including Term) • Hospital Acquired Infection • Administration failure i.e. failure to arrange follow up appointment/delayed or lost results • Major incident (eg fire) • Loss of property/theft

HDUHB MATERNITY TRIGGER LIST 2023

Maternal / Birth

1. Eclampsia*
2. Post-partum Haemorrhage >1500ml*
3. Maternal Death*
4. ITU (incl. HDU) admission*
5. Pulmonary Embolism*
6. Venous Thromboembolism/DVT*
7. Uterine Rupture*
8. Significant infection *i.e. MRSA, CDiff*
9. Medication error
10. Shoulder dystocia*
11. Unintentionally retained swab, Incorrect swab / Instrument count
12. 3rd/ 4th degree tear
13. Undiagnosed breech in Labour*
14. Unsuccessful forceps or ventouse resulting in Caesarean Birth
15. Double instrument use at an assisted birth*
16. Readmission (postnatal) of Mother*
17. Postponement of induction of labour or elective procedure
18. Stillbirth / Fetal loss ≥22wks*
19. Category 1 emergency/ unplanned Caesarean Birth
20. Antenatal screening test not conducted / not followed up
21. Preterm birth <32 weeks gestation (twins <34 weeks gestation)
22. Maternal injury during birth, bladder/bowel injury
23. Birth of baby with no professional in attendance (eg BBA, in transit)
24. Delay in planned care of >4 hours (eg delayed ARM)
25. Decision to caesarean birth time not met (eg Cat 2 >75 minutes)

Fetal/ Neonatal

1. Baby abduction incl. attempted abduction
2. Neonatal death**
3. Undiagnosed fetal abnormalities**
4. Unexpected birth trauma (including laceration/ bruising) to baby during birth**
5. Prescribing error
6. Readmission of infant**
7. Unexpected BWC <10th centile**
8. Failure to follow safeguarding procedure
9. Cord pH <7.05 Arterial / <7.1.0 venous
10. Dropped baby

Organisational

1. Escalation policy triggered *(due to staffing issues, bed/capacity issues)*
2. Equipment / facilities failure
3. Verbal or physical threat to staff or patient
4. RCOG Duties of the On Call Consultant not met (eg >30 minutes)

* indicates trigger is listed under Maternity Care: Maternity Triggers
**indicates trigger is listed under Neonatal Care: Neonatal Triggers

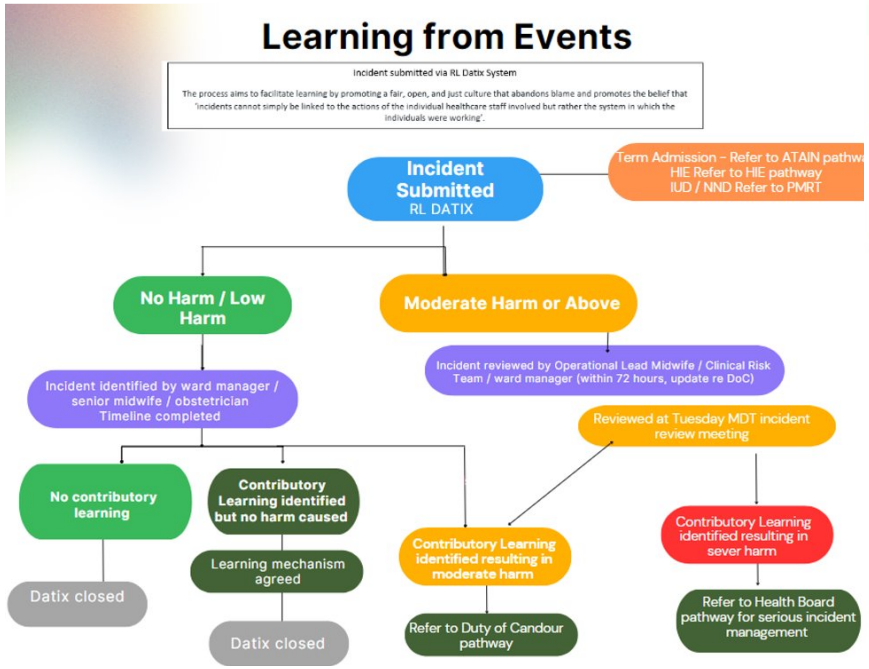
Please note this list is not exhaustive and clinicians should use their discretion
Note; Patient Fall and Pressure Damage warrant a Datix investigation.

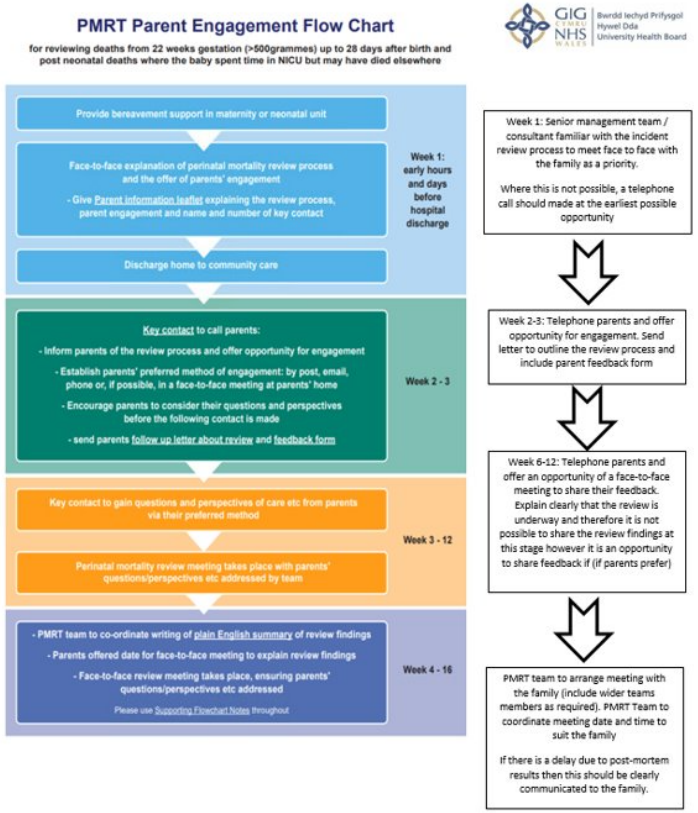
HDUHB Maternity Trigger List v1.5 July 2023

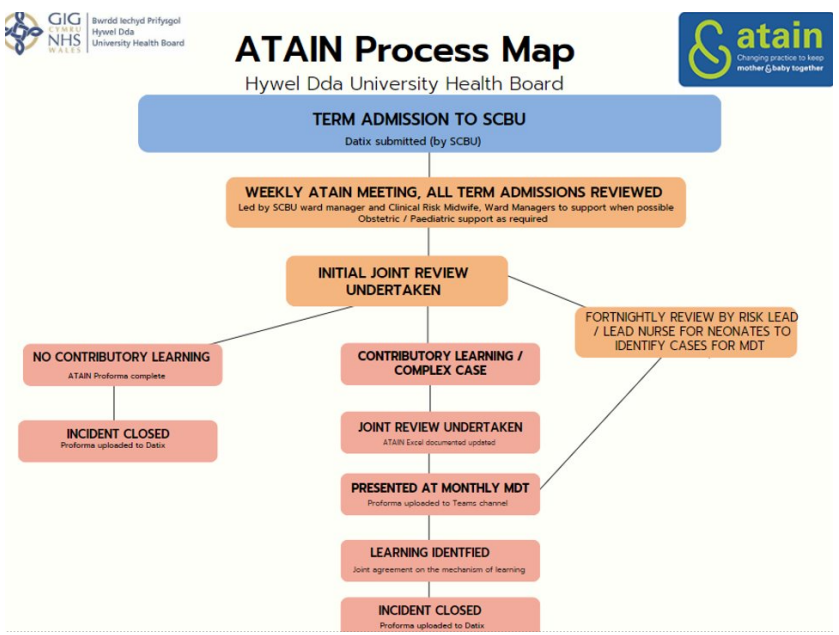
Gaps in incident reporting and investigation

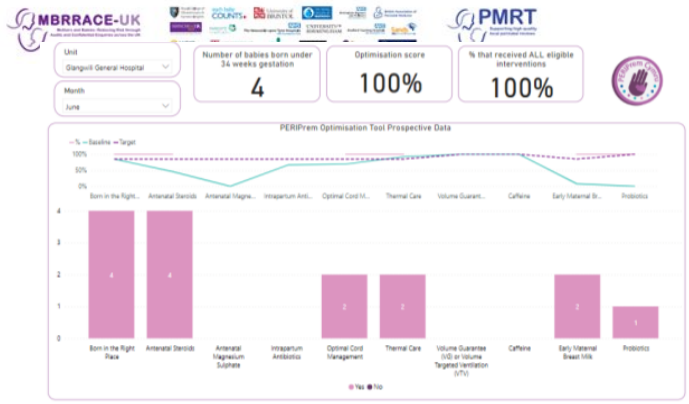
Standardisation of review pathways of adverse events across Maternity and Neonatal Services has been undertaken

There are dedicated governance leads across midwifery, obstetric, neonatal, paediatric and anaesthetic services with a triangulated governance framework to support oversight









Failures in leadership and governance.

The best way to reduce harm ... is to embrace wholeheartedly a culture of learning."

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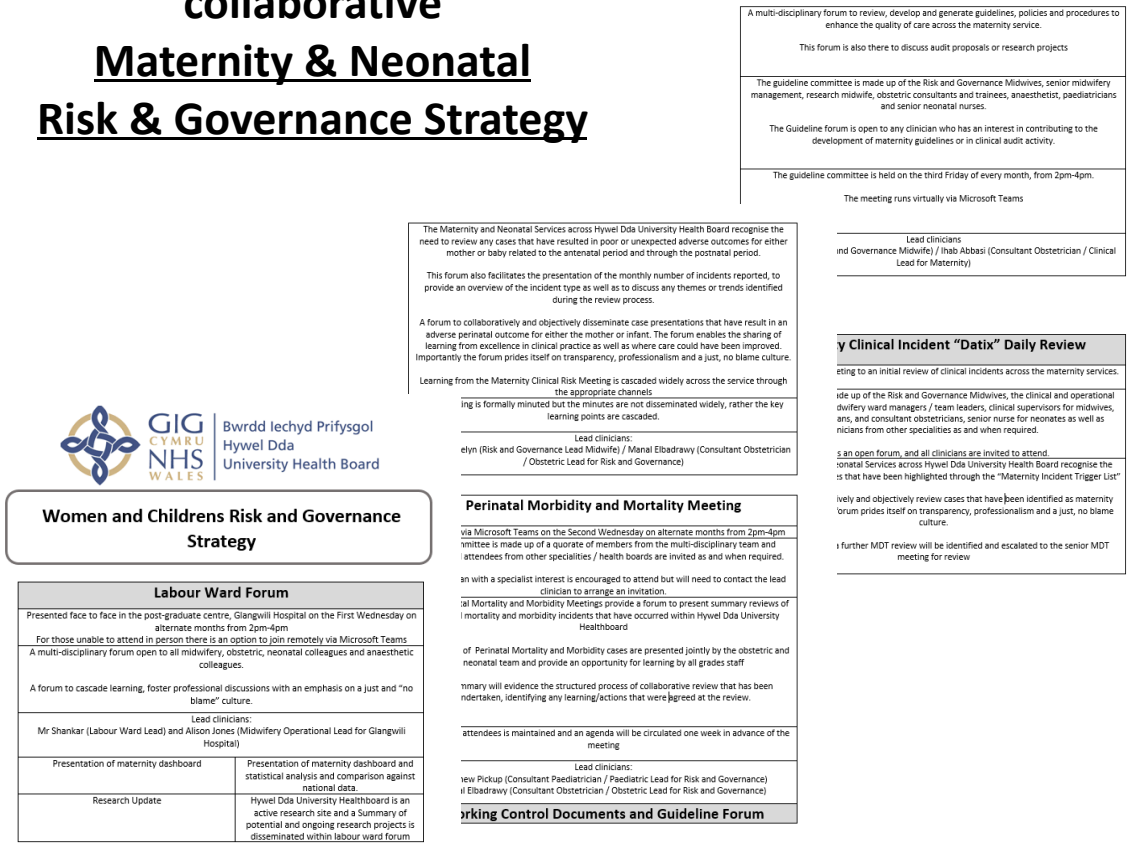
Implementation of a collaborative Maternity & Neonatal Risk & Governance Strategy



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Women and Childrens Risk and Governance Strategy

Labour Ward Forum	
Presented face to face in the post-graduate centre, Glangwili Hospital on the First Wednesday on alternate months from 2pm-4pm For those unable to attend in person there is an option to join remotely via Microsoft Teams	
A multi-disciplinary forum open to all midwifery, obstetric, neonatal colleagues and anaesthetic colleagues. A forum to cascade learning, foster professional discussions with an emphasis on a just and "no blame" culture.	
Lead clinicians: Mr Shankar (Labour Ward Lead) and Alison Jones (Midwifery Operational Lead for Glangwili Hospital)	
Presentation of maternity dashboard	Presentation of maternity dashboard and statistical analysis and comparison against national data.
Research Update	Hywel Dda University Healthboard is an active research site and a Summary of potential and ongoing research projects is disseminated within labour ward forum

Maternity & Neonatal Clinical Risk Meeting
Delivered via Microsoft Teams on the second Friday of every month from 2pm-4pm.
The committee is made up of a quorate of members from the multi-disciplinary team and additional attendees from other specialities / health boards are invited as and when required. Any clinician with a specialist interest is encouraged to attend but will need to contact the lead clinician to arrange an invitation.

A multi-disciplinary forum to review, develop and generate guidelines, policies and procedures to enhance the quality of care across the maternity service. This forum is also there to discuss audit proposals or research projects
The guideline committee is made up of the Risk and Governance Midwives, senior midwifery management, research midwife, obstetric consultants and trainees, anaesthetist, paediatricians and senior neonatal nurses. The Guideline forum is open to any clinician who has an interest in contributing to the development of maternity guidelines or in clinical audit activity.
The guideline committee is held on the third Friday of every month, from 2pm-4pm. The meeting runs virtually via Microsoft Teams
Lead clinicians ınd Governance Midwife) / Ihab Abbasi (Consultant Obstetrician / Clinical Lead for Maternity)

The Maternity and Neonatal Services across Hywel Dda University Health Board recognise the need to review any cases that have resulted in poor or unexpected adverse outcomes for either mother or baby related to the antenatal period and through the postnatal period. This forum also facilitates the presentation of the monthly number of incidents reported, to provide an overview of the incident type as well as to discuss any themes or trends identified during the review process. A forum to collaboratively and objectively disseminate case presentations that have result in an adverse perinatal outcome for either the mother or infant. The forum enables the sharing of learning from excellence in clinical practice as well as where care could have been improved. Importantly the forum prides itself on transparency, professionalism and a just, no blame culture. Learning from the Maternity Clinical Risk Meeting is cascaded widely across the service through the appropriate channels
ing is formally minuted but the minutes are not disseminated widely, rather the key learning points are cascaded.
Lead clinicians: elyn (Risk and Governance Lead Midwife) / Manal Elbadrawy (Consultant Obstetrician / Obstetric Lead for Risk and Governance)

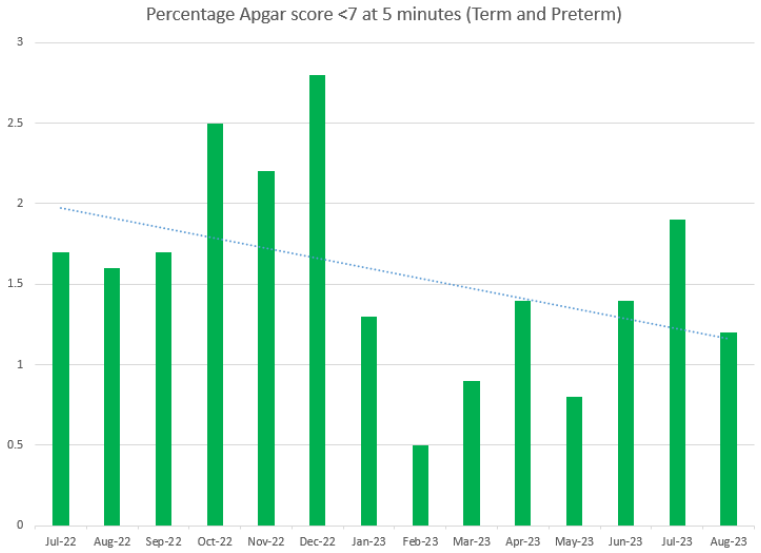
y Clinical Incident "Datix" Daily Review
eting to an initial review of clinical incidents across the maternity services.
ide up of the Risk and Governance Midwives, the clinical and operational dwifery ward managers / team leaders, clinical supervisors for midwives, ans, and consultant obstetricians, senior nurse for neonates as well as nicians from other specialities as and when required.
s an open forum, and all clinicians are invited to attend.
onatal Services across Hywel Dda University Health Board recognise the s that have been highlighted through the "Maternity Incident Trigger List"
ively and objectively review cases that have been identified as maternity orum prides itself on transparency, professionalism and a just, no blame culture.
further MDT review will be identified and escalated to the senior MDT meeting for review

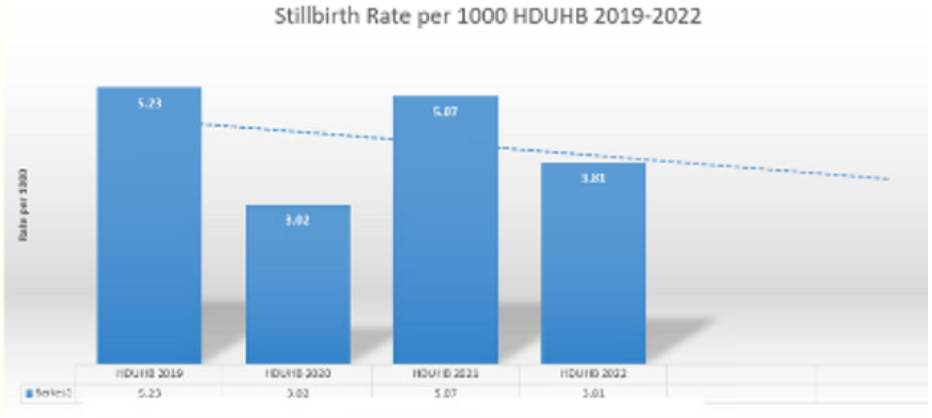
Perinatal Morbidity and Mortality Meeting
via Microsoft Teams on the Second Wednesday on alternate months from 2pm-4pm
mittee is made up of a quorate of members from the multi-disciplinary team and attendees from other specialities / health boards are invited as and when required.
an with a specialist interest is encouraged to attend but will need to contact the lead clinician to arrange an invitation.
al Mortality and Morbidity Meetings provide a forum to present summary reviews of mortality and morbidity incidents that have occurred within Hywel Dda University Healthboard
of Perinatal Mortality and Morbidity cases are presented jointly by the obstetric and neonatal team and provide an opportunity for learning by all grades staff
mmary will evidence the structured process of collaborative review that has been ndertaken, identifying any learning/actions that were agreed at the review.
attendees is maintained and an agenda will be circulated one week in advance of the meeting
Lead clinicians: ew Pickup (Consultant Paediatrician / Paediatric Lead for Risk and Governance) l Elbadrawy (Consultant Obstetrician / Obstetric Lead for Risk and Governance)
rking Control Documents and Guideline Forum

Paradigm shift from individual learning to wider system learning.

The system is focused on learning, locally and nationally, and makes extensive use of improvement methodology to test and implement the necessary changes. Near misses are reviewed regularly to promote learning and system improvements.

Failures in leadership and governance.





1 Reduction in the number of adverse events

Following the implementation of the QI project there has been a reassuring reduction in the number of adverse events. Including a reduction in the babies who are stillborn, a reduction in the number of babies who are in poor condition at 5 minutes and a reduction in the number of women / birthing people who experience a Haemorrhage following birth

Quarterly **Mortality Review Forum** with the **All Wales Maternity and Neonatal Network** to comprehensibly and objectively review all Neonatal deaths from within the Health Board.

Quarterly **"Hypoxic Ischaemic Encephalopathy"** Forum (babies at risk of long-term physical & cognitive issues) with the **All Wales Maternity and Neonatal Network**

Failures in leadership and governance

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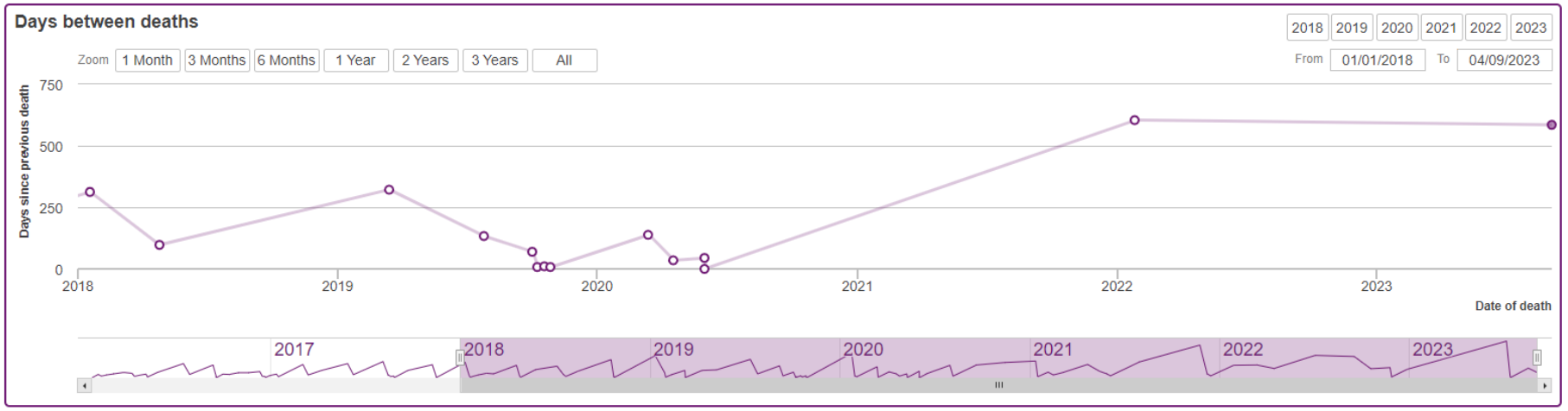
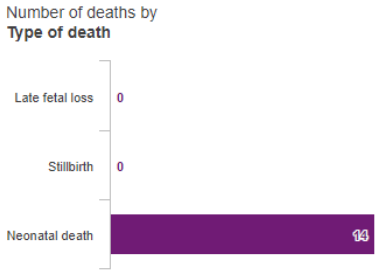
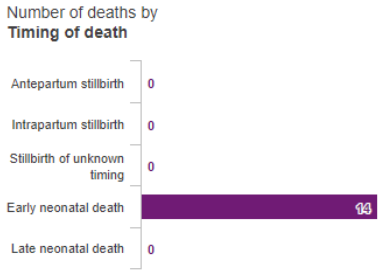
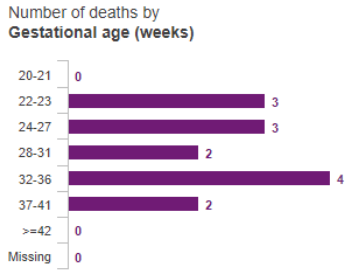
MBRRACE-UK

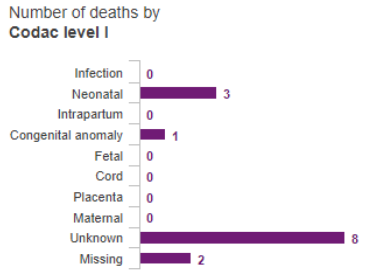
Neonatal Deaths











<u>Thematic Review of Neonatal Deaths in HDUHB</u>

Identify key themes and trends to influence learning across maternity and neonatal services

On-going engagement with the Quality and Patient Safety Team to ensure objectivity and transparency of case reviews

Recommendation

- For the Quality, Safety and Experience Committee to take assurance from the actions underway in response to the Thirwall Enquiry.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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