Enw'r Pwyllgor: Name of Sub-Committee:	Exception Report from Listening and Learning Sub-Committee
Cadeirydd y Pwyllgor: Chair of Sub-Committee:	Chantel Patel, Chair
Cyfnod Adrodd: Reporting Period:	August 2023

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

The Sub-Committee met on the 12 July 2023 and received a number of presentations and individual cases relating to the area of maternity services.

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

Patient Experience

The maternity service presented a number of case studies where learning had been identified.

Case 1

The investigation found that surgery had been appropriately performed; however there was a missed opportunity for early recognition of the patient's deterioration and a missed opportunity for early return to theatre.

In response to learning from events, a "safety huddle" had been introduced prior to all planned caesarean births. A teaching presentation has been shared with staff around the importance of the World Health Organisation (WHO checklist).

The case has been presented at the Multi Disciplinary Clinical Risk Meeting and key learning points shared around the importance of early recognition of a deteriorating patient. Training had been delivered to all staff in PROMPT (obstetric drill training) on caring for a deteriorating woman.

Case 2

The investigation found that the Venous Thromboembolism (VTE) risk assessment tool currently in use may negatively impact on consistent and objective risk assessments being undertaken. There was a missed opportunity to perform the purpose VTE risk assessment following admission to hospital.

Learning had been undertaken in the following areas:
Sharing medical records; breakdown of the relationship between the Health Board and the woman; impact of the appointment of the advocate; and earlier transfer to concerns team.
The revised VTE pathway was now in place and would remove ambiguity from the diagnosis of thrombosis. The learning had been shared at a Lunch and Learn meeting; via posters; and a safety briefing email informing staff that the new tool is live. The Service was auditing the new training book for midwives regarding pressure sores.

In this case, it was noted that an omitted piece of the medical record had caused the initial breakdown in communication.

Case 3

The case involved a breakdown of communication. The patient has autism and there was a missed opportunity to implement adjustments to support her. For example, the patient felt obliged to agree when asked “Are you happy with the baby’s movements” as due to her autism she didn’t understand the nuance of the question. A direct question would have aided the understanding.

The service has implemented an individualised sticker in each maternity hand held record to ensure all the question regarding additional support is asked of all women/birth person. The sub-group discussed the development of the Maternity passport tool, and how it’s implementation would be a fantastic resource if rolled out across the service. There are resources within departments for individual training; however the maternity template would be easily transferable to apply across services including community and primary care.

Maternity Service – Survey Feedback

The Sub-Committee received the findings from 4 surveys using data from Hywel Dda’s Facebook page/QR codes from March 2022 to July 2022.

Overall the feedback stated that the midwives were “amazing”.
The concerns included:-

- Continuity of care.
- Partner visiting (Covid-19 restrictions still in place).
- Waiting times in antenatal.
- The waiting areas in general.
- Disorganisation and communication/ patients not feeling listened to.

You said / we listened action plans had been implemented, as a result of the feedback:

- Ongoing audit on clinic times.
- Doctors stamp to allow for continuity of care.
- The restructure of clinic timing.
- Post-natal videos.
- Survey always placed at front of maternity notes.
- Birth preference list developed.

Civica Feedback

A presentation was received on the feedback received via the Civica system relating to the area of Maternity Services. The benefits of the system are now more apparent. Uptake had increased in the last twelve months with ease of use of advanced technology like QR codes and Facebook pages. Over 80 different services now had access to the system.

The service returned a 90% positive rating with 40% delighted. Overall 90.9% positive response over the past 12 months. “Your NHS Wales Experience” received 10 extra responses at 70% positive.

Positive feedback was linked to patients feeling supported, listened to and involved with the decision making process.

When the feedback was negative it was based around the patient feeling scared and anxious, not being listened to and being a burden.

Positive feedback on the Civica system does reference staff by name and this is being fed back to the staff members creating positive reinforcement. Civica training is held every Wednesday, with 285 staff trained to date. Staff present agreed to promote the training.

Complaints

Two Maternity Service cases were presented (ref 1335, 5820).

In case 1335, learning indicated that the patients symptoms and blood results should have resulted in the midwife asking the patient to attend for a review. Advice given was inappropriate and should have resulted in an admission to the ward and an opportunity for senior obstetric review.

Case 5820 involved a lack of communication. The Case was presented to the Labour Ward Forum as a means of circulating learning in terms of the need to assign a scribe for all neonatal resuscitation events. Quarterly audits were agreed to check adequate supplies of equipment on the neonatal resuscitation trolley and procedure for regular stock checking.

Public Services Ombudsman for Wales

Three cases that had been referred to the Ombudsman were reviewed (1075, 18139, 19360). One case had been upheld; two were partially upheld.

1075 - The Ombudsman's investigation found that, whilst the overall care provided was to an appropriate standard, there had been a lost opportunity to reach a different decision on the management of the patient's injury, as the Health Board had not properly discussed with her the option of surgery at an earlier point.

There was no evidence that the Health Board had made any reasonable adjustments, in accordance with the Equality Act 2010, to account for the patients autism and enable her to properly understand and participate in the decisions about her clinical management (including any earlier surgery).

This loss of opportunity contributed to the patient's distress and anxiety. To that extent, the complaint was upheld.

18139 - The Ombudsman found that the patient's bowel problems were investigated and treated appropriately, and that in the circumstances, follow up monitoring was not necessary after her initial discharge from hospital.

The Ombudsman found that there were several possible reasons for the inflammatory markers being raised, and she did not identify any failings by Hywel Dda or Swansea Board, in investigating and treating the cause.

The Ombudsman also found that when the patient's symptoms escalated she was promptly and appropriately referred for a scan. The Ombudsman did not uphold these aspects of the complaint. The Ombudsman found that it was necessary for the patient to be fitted with an arterial cannula when she was undergoing major surgery, and that when her ischaemic hand was brought to the attention of medical staff, appropriate action was taken. However, the Health Board's monitoring of the arterial cannula fell short of the expected requirements. Whilst the Ombudsman could not say with any certainty that the patients ischaemic hand would have come to light earlier if it had been appropriately monitored, it is possible that it would. The Ombudsman considered it likely, on the balance of probabilities, that it was the patient's husband who brought the issue to the attention of nursing staff. Whilst the Ombudsman did not find that the shortcomings in monitoring had an adverse impact on the outcome, she considered it likely that they resulted in distress and anxiety to both the patient and her husband. To this extent, the Ombudsman upheld the complaint.

19360 - The case alleged that there was a failure to offer the patient a hysterectomy in 2016 to manage a finding of atypical hyperplasia; a delay in diagnosing endometrial cancer; failure to diagnose iron deficiency anaemia before September 2020; and delays in complaint management.

It was agreed to invite the patient to engage with the Putting Things Right redress process, should she wish to do so, in respect of the failure to offer appropriate treatment for her symptoms of ongoing bleeding in 2019. Also, to share the findings of the Ombudsman's investigation at an appropriate Gynaecological Oncology consultant forum to ensure wider learning from the complaint, noting in particular the record keeping requirements around counselling for treatment and the accuracy of the terminology used in the records.

The Sub-Committee spent time discussing the Public Services Ombudsman recently received 'Ground-hog Day 2' report which was heavily critical of the culture of complaints management in NHS Wales. Case studies for each Organisation were shared, for Hywel Dda, timeliness was the main criticism from the report. This led to a further discussion on the revised complaints investigation toolkits and new performance measures currently being rolled out across the services.

Policies for Approval

Management of Claims Policy (Ref 004)

The Sub-Committee approved the Claims Management Policy for submission to Quality, Safety and Experience Committee for final ratification. The Policy would be subject to a two week staff consultation period.

Management of Concerns Policy (Ref 894)

The Sub-Committee approved the Management of Concerns Policy for submission to Quality, Safety and Experience Committee for final ratification. This would be subject to a two week staff consultation period. The policy had been updated to take account of recent legislation on Duty of Candour and revised Putting Things Right Guidance issued in 2023. It was noted that a full review of Putting Things Right would be undertaken by Welsh Government in 2024 and therefore

minor changes had been applied to update the legislation, pending consultation and more substantial amendment.

Being Open/Duty of Candour Guidance (Ref 244)

The Sub-Committee agreed to discontinue with this guidance, as the new Duty of Candour legislation and associated guidance has now been issued, which replaces the information in the document.

Internal Audit Reports

Two internal audit reports recently discussed at Audit and Risk Assurance Committee. The reports related to patient experience and learning from events.

The proposed actions were reviewed by the Sub-Committee and endorsed. The planned approach for review of the Improving Experience Charter was approved. The actions would be monitored by the Sub-Committee

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

Medical Records Management - access to records; quality of the record; and disclosure processes (involving redaction and scanning). This was a risk to the management of concerns and compliance with the disclosure requirements for proceedings and legal claims.

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 (including scanning and disclosure).
- 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:

- Discuss whether the assurance and actions taken by the Sub-Committee to mitigate the risks are adequate.
- The Sub-Committee is asked to ratify the decision to discontinue the Being Open/Duty of Candour Guideline.

Dyddiad y Cyfarfod Pwyllgor Nesaf:
Date of Next Sub- Committee Meeting:

September 2023- theme palliative care/ bereavement