



INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL

Clinical Review Programme

Cwm Taf Morgannwg University Health Board

Technical Analysis Report – Maternal Category
January 2021

The Independent Panel was established by Welsh Government in response to the findings of an independent review of maternity services in the former Cwm Taf University Health Board.

Independent Maternity Services Oversight Panel - Clinical Review Programme

Technical Analysis of the Maternity Mortality and Morbidity Category Clinical Reviews

Foreword

On 30 April 2019, following the publication of a [review](#) conducted jointly by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, the Minister for Health and Social Services announced that he was placing maternity services in the former Cwm Taf University Health Board in 'special measures'.

As part of a package of measures designed to support this intervention, the Minister appointed an independent panel to provide the oversight which was necessary to ensure that Cwm Taf Morgannwg University Health Board addressed the improvements identified by the Royal Colleges in a timely, open and transparent manner which placed the women and families at the heart of the process.

This report sets out the thematic findings from the review of the maternity mortality and morbidity category, which is the first element of the Clinical Review Programme to be completed.

Independent Maternity Services Oversight Panel



Mick Giannasi (Chair) is the Chair of Social Care Wales. He was formerly the Chair of the Board of the Welsh Ambulance Service NHS Trust, a Welsh Government Commissioner for Isle of Anglesey County Council and the Chief Constable of Gwent Police.



Cath Broderick (Lay Member) is an Honorary Fellow of the Royal College of Obstetricians and Gynaecologists and the author of the 2019 report, *Listening to Women and Families about Maternity Care in Cwm Taf*. She has extensive experience in patient and public engagement and supported the response to the Kirkup Inquiry in Morecambe Bay.



Alan Cameron (Obstetric Lead) has 26 years' experience as a Consultant Obstetrician and has recently been appointed as the National Clinical Lead in Obstetrics and Gynaecology for the Scottish Maternity and Children Quality Improvement Collaborative.



Christine Bell (Midwifery Lead) has over 30 years' experience working as a midwife in England, ten of those as a Head of Midwifery and is a designated Midwifery Assessor with the Royal College of Obstetricians and Gynaecologists.

1 WHAT WE DID

1.1 Background

The Independent Maternity Services Oversight Panel was established by the Welsh Government in response to the Royal Colleges' review of the maternity and neonatal services provided by the former Cwm Taf University Health Board. In accordance with its terms of reference, the Panel established an independent programme to clinically review historical maternity and neonatal cases.

There are four cohorts within the Clinical Review Programme. The first two (known as the '2016-2018 look-back') provided the initial focus.

1. 01 January 2016 - 30 September 2018 cases identified in advance of the Royal Colleges' review (previously referred to as the '43').
2. 01 January 2016 - 30 September 2018 cases subsequently identified through inclusion criteria established by the Panel's Clinical Leads.
3. The 2010 - 2016 look-back. The criteria utilised for this group will be determined using the outcomes from the above two cohorts.
4. Self-referrals.

N.B. Those women and families who have self-referred will have a review of their care regardless of whether or not they fit the inclusion criteria, albeit this might not necessitate a full independent clinical review. A separate process for considering self-referred cases has been agreed with the Health Board.

The Clinical Review Programme is led by the Panel's Clinical Leads, Christine Bell and Alan Cameron.

1.2 Clinical Review Programme

The first phase of the Clinical Review Programme focuses on cases identified for the look-back period 01 January 2016 - 30 September 2018, which includes the original 43 cases identified ahead of the Royal Colleges' review.

The programme organised the cases into three categories as detailed on the following page:-

CATEGORY	DESCRIPTION
Maternal mortality and morbidity	Care of mothers, including those who needed admission to the intensive care unit (ITU)
Stillbirths	Babies who sadly were stillborn
Neonatal mortality and morbidity	Babies who sadly died following birth or needed specialist care

The reviews are being progressed by category in the order shown above. The maternity mortality and morbidity category, which comprises of 28 cases, has now been completed.

The clinical reviews are being undertaken by multidisciplinary teams of Midwives, Obstetricians, Anaesthetists and Neonatologists. The teams commenced work in earnest during early Spring 2020 following induction and training in the use of the designated review tool (see *Appendix A*) to report their findings. The review identifies areas where clinical practice could have been improved and provides recommendations to support the Health Board's learning. An escalation process is in place for any concerns requiring immediate attention.

Once the review teams have completed their reviews, they are subject to a quality assurance check before submission to the Quality Assurance Panel. The Panel comprises the Clinical Leads, supported by a Neonatal Lead, an Anaesthetic Lead and the Assistant Director of Quality and Safety at the NHS Wales Delivery Unit who leads the intervention into the Health Board's systems and processes for managing incidents and concerns and has extensive knowledge of clinical review methodology and developed the original review tool. Lay input and women's advocacy is provided by the Cwm Taf Morgannwg Community Health Council's Chief Officer. The Panel's purpose is to provide quality assurance of the overall process to ensure consistency and to inform actions needed in response to identified outcomes of the clinical reviews.

Anonymity of the women and their families is maintained throughout the clinical review and quality assurance processes.

Once the quality assurance process is complete, the Panel prepares a summary of the findings of the clinical review for the individual women and their families, as well as sharing the recommendations for learning with the Health Board. The Health Board have developed a comprehensive Maternity Improvement Plan which is work stream and pathway-led to take forward the areas of learning identified.

This report brings together the findings of the clinical reviews and the Quality Assurance Panel through quantitative and qualitative analysis, setting this alongside the feedback received from women and families as well as the Royal Colleges' recommendations.

2 WHY WE DID IT

Engaging with women and families who use maternity services and learning from their experience, especially when things go wrong, is at the heart of improving future care and the quality of maternity services.

During their review, the Royal Colleges provided a number of patient and public engagement opportunities which are reported in the supplementary report entitled *Listening to Women and Families about Maternity Care in Cwm Taf*. A copy of the report can be accessed [here](#).

Every woman whose care was reviewed within the maternity mortality and morbidity category was given the opportunity to provide individual feedback, which was shared with the clinical review teams to provide a holistic view of care. The feedback provided by women has been analysed and the key themed results are reported here. The thematic analysis from this category will inform an overarching report into the experience of women and families which will be published once the review and quality assurance of all three categories within the 2016-2018 look-back has been completed.

Although the number of stories shared is small in contrast to the total number of clinical reviews within this category, the narratives provide a high level of consistency when viewed alongside the clinical review analysis. There are benefits to undertaking a thematic analysis of women's stories alongside clinical reviews. Women and families talk about the whole pregnancy journey and explore their experience in depth, which may include their previous experiences of pregnancy, whilst the clinical review utilises information available in the woman's records looked at from a clinical perspective which may focus on a moment in time during the birth experience.

The primary material used for thematic analysis came from the women's responses to the women's and families' experience pro-forma (*Appendix B*). The responses were then analysed to identify a number of broad topics that reflected those issues which women and their families raised most frequently. These can be summarised as follows:-

2.1 Communication - Although there are examples of good practice in effective communication and empathy from individual members of staff or teams, the experiences shared by women do reflect the impact of poor communication and listening. It is clear from the narratives that good communication and appropriate information have an impact on women when making their choices, in understanding what is happening during their maternity experience, feeling listened to and valued, as well as ultimately feeling that they have a degree of influence and are empowered. The negative impact on women's confidence when staff displayed uncertainty in the management of a woman's condition is highlighted. Poor communication between different specialties and across teams had an impact during pregnancy, birth and especially in relation to aftercare, with examples describing poor communication across the different teams, from ITU, maternity, community midwives and district nurses, resulting in a confused picture and episodes of panic and emergency action.

2.2 Information - Women wanted accessible, timely and appropriate information with less ambiguity, in order to make decisions, support their choices and understand who to contact when they needed help or reassurance. Too often women and their families were left with either no information or too much information resulting in delay and confusion. This was particularly highlighted when women had been separated from their babies and families as a result of emergency care outside of the maternity unit.

2.3 Holistic care (understanding the needs of women and their families) - A specific theme has been the involvement of women's families and friends, as well as the failure by staff to address their needs. In these cases, the clinical response to the woman's condition was paramount but the impact on wider care and the importance of support from family and friends was not taken into account. Women not only experienced physical difficulties that made caring for their baby challenging, but also described the increased emotional needs following a traumatic experience that would suggest that the input of mental health support would be beneficial.

2.4 Monitoring and recognising red flags for escalation - A number of women placed emphasis on the impact of a failure to monitor their progress and a corresponding lack of care. The consequences of leaving women and families unattended without regular checks, as well as making assumptions that all was well were significant in these accounts. It is unclear from the women's accounts whether gaps in monitoring or failures to pick up changes in their condition was due to staff shortages or linked to poor practice. However, more systematic monitoring could have resulted in situations that did not escalate to the "*panic*" described by several women.

The importance of understanding the whole picture of a woman's health and history is underlined in the stories shared. In a number of cases the underlying condition was a factor in the woman's birth experience and recovery when things did not go as planned.

3 WHAT WE FOUND

28 clinical cases within the maternal category were reviewed using the agreed clinical review tool. The tool assesses care delivery in the following areas:

▪ Pre-pregnancy or preconception care	▪ Education, knowledge and training
▪ Assessment or point of entry to care	▪ Documentation
▪ Diagnosis or in the recognition of high-risk status	▪ Discharge or transfer from care
▪ Referral to specialist	▪ Communication
▪ Treatment	▪ Policies and procedures
▪ Clinical leadership	▪ Woman or her family

Where care has been found to have fallen below expected standards within one or more of these areas, it is classified as a modifiable factor. The clinical review team then attribute a significance rating which determines to what extent the modifiable factor could reasonably be expected to have contributed to the poor outcome and/or experience. If the factor did not affect the outcome, it is classified as wider learning to be shared.

KEY FINDINGS

At least one modifiable factor was found in 27 of the 28 cases (96%).

68% (19 cases) were assessed as having a major modifiable factor that contributed significantly to the poor outcome, where different management would reasonably have been expected to alter the outcome.

Of the 19 cases with major modifiable factors, more than one major factor was found in 63% (12 cases).

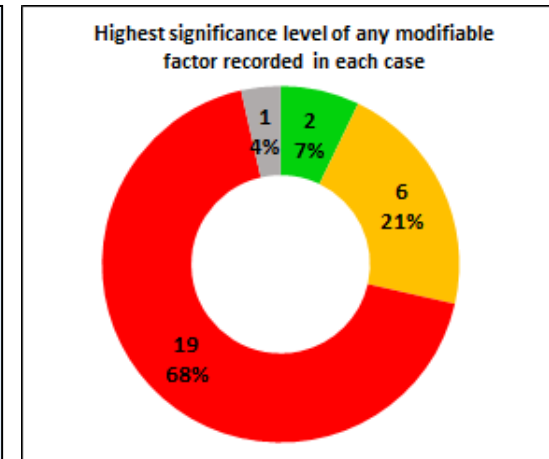
The highest number of major modifiable factors (14 cases) was related to Diagnosis of a High Risk Status.

The second highest (seven cases) was related to Treatment and the third highest was in the category of Clinical Leadership (five cases).

The total highest number of modifiable factors in all categories was in Treatment and Diagnosis of a High Risk Status which was identified in 20 cases. Clinical Leadership was identified as a modifiable factor in 15 of the 28 cases.

Communication was raised most often by women and families as a significant issue in their care.

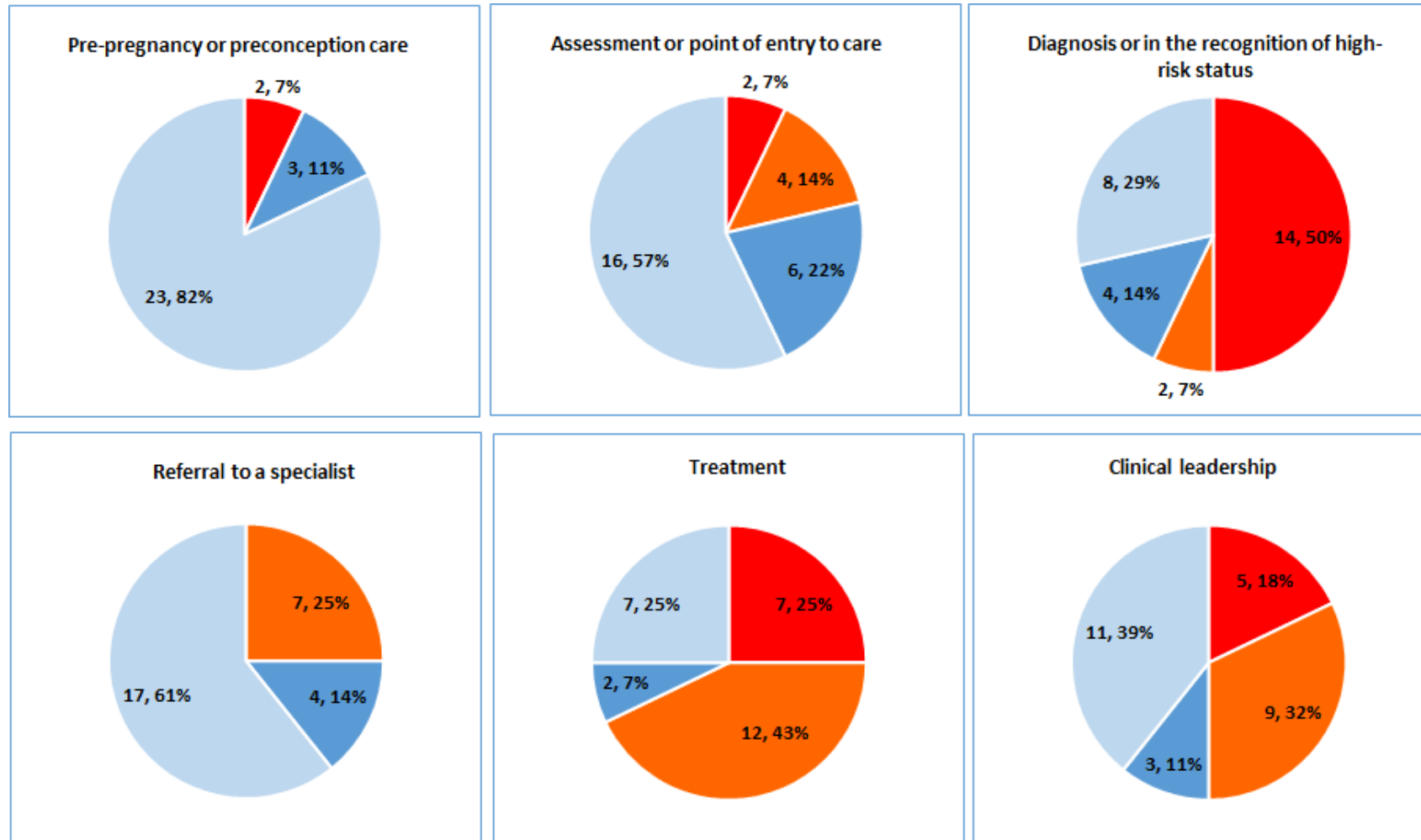
An internal review was undertaken in 13 cases and of these, five serious incident investigations were undertaken.



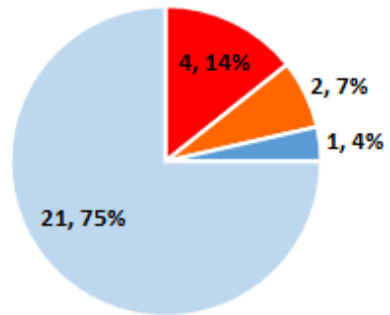
■	Major Modifiable Factor
■	Minor Modifiable Factor
■	Wider Learning
■	No Modifiable Factor Present

IN MORE DETAIL

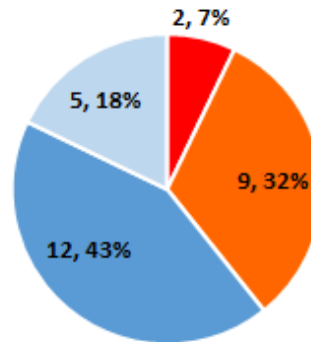
- Major - Factor contributed significantly to the death/poor outcome. Different management would reasonably have been expected to alter the outcome.
- Minor - Factor was a contributory factor. Different management might have made a difference but unlikely to have changed the overall outcome.
- Wider Learning - Although lessons can be learned, it did not affect the eventual outcome.
- No modifiable factors present of this type following review.



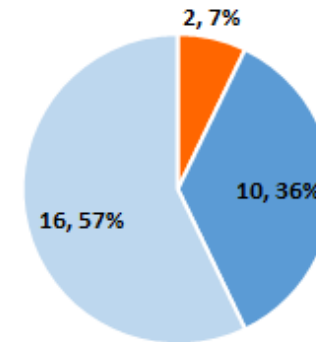
Education, Knowledge, Training



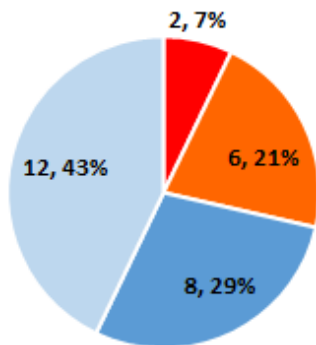
Documentation



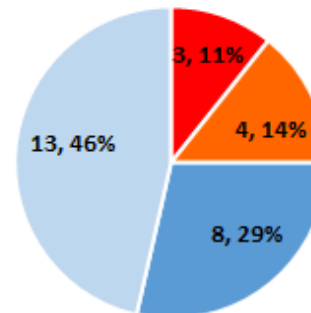
Discharge or transfer from care



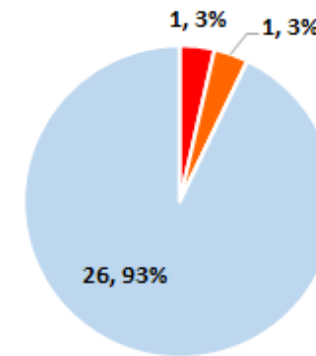
Communication



Policies and procedures



Woman and her family



Major Modifiable Factors

Major modifiable factors, where different management **would** reasonably have been expected to alter the outcome, were identified in 19 (68%) cases and of these, 12 cases (63%) had more than one major modifiable factor identified.

Minor Modifiable Factors

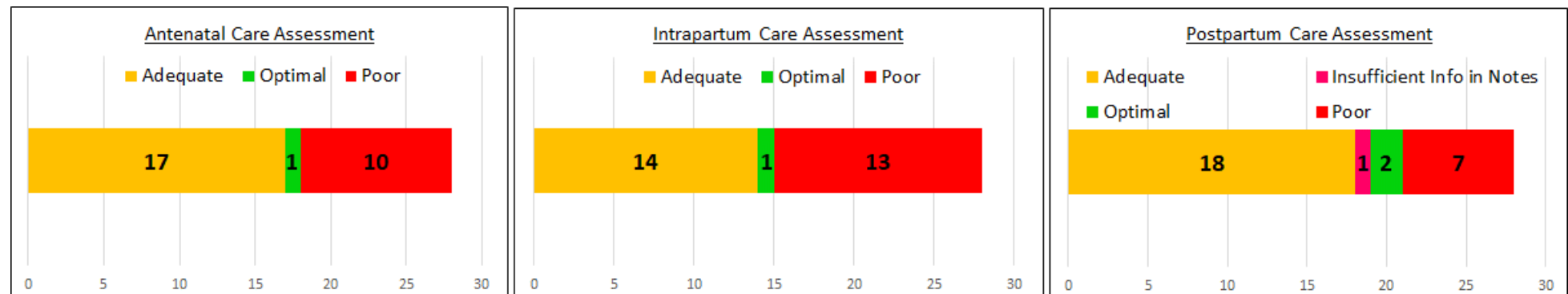
Minor modifiable factors, where different management **may** have resulted in a different outcome, were identified in 22 (79%) of the 28 cases. In 16 of these cases (73%), major modifiable factors were also identified. In six cases (21%) a minor modifiable factor was the highest factor identified.

Cases for Wider Learning

In 23 cases there was a factor with wider learning implications that did not affect the outcome but wider learning would benefit others. In two of these cases it was the highest level of significance found.

Overall Assessment of Antenatal, Intrapartum and Post Natal Care

Care of women in the antenatal period was assessed as either optimal or adequate in 64% (18) of the 28 cases, with 10 (36%) women receiving poor care. 15 women (54% of cases) received optimal or adequate intrapartum care, with 13 (46%) women receiving poor care. 20 women received optimal or adequate postnatal care, with seven women receiving poor care. One case could not be assessed as post-natal notes were not available for review.



THREE CLINICAL CATEGORIES OF MOST CONCERN

Three categories were identified within the review process as being of greatest concern:

1. Diagnosis of high risk status
2. Treatment
3. Clinical leadership

1. **Diagnosis of a High Risk Status** - Care fell below expected standards in 20 cases, with 27 individual factors identified. Of the 14 women where one or more **major** modifiable factor was identified, seven women (50%) experienced a delay in diagnosis or recognition of their high-risk status, while five women experienced a delay in the recognition of abnormal signs such as abnormal blood pressure. There was a delay in recognising surgical complications in four cases and in two cases there was a failure to recognise surgical complications. Failure to order or check investigations was identified in four cases and for two women there was inadequate monitoring of their baby's growth during their pregnancy. Of the two women where one or more **minor** factor was identified in this area, one woman experienced a delay in the recognition of abnormal signs and one woman experienced a delay in checking investigation results and a failure to order or check investigations was identified.

An area of high concern: delay in recognition of a high risk status

2. **Treatment** - Care fell below expected standards in 21 cases with 41 individual factors identified. Of the seven women where one or more **major** modifiable factor was identified, no plan of care was identified in four cases, there was a delay in treatment for three women and there was a failure to act on a high risk situation in three cases. Of the 12 women where one or more **minor** modifiable factor was identified, nine women experienced a delay in treatment and six women did not have a plan of care.

An area of high concern: no plan of care and delay in treatment

3. **Clinical Leadership** - Care fell below expected standards in 15 cases. Of the five women where one or more **major** modifiable factor was identified, there were four cases where there was a failure to consult someone more senior and three where there was a failure to check on the work of a more junior member of staff. Failure to consult someone more senior was also identified in nine cases with more than one **minor** modifiable factor. There was a failure to consult someone more senior in four cases and in three cases an inappropriate grade (experience) of staff.

An area of high concern: failure to consult someone more senior

WOMEN AND FAMILIES HIGHEST AREA OF CONCERN

- Communication

Although this was a clinical review seen through the eyes of clinicians, women and families raised their concerns by sharing their stories. The concern raised most often was about communication.

There were 16 women whose care was below the expected standard in relation to communication; two were identified with **major** modifiable factors, six **minor** and eight **wider learning**.

For two women communication between departments and specialities was identified as a major modifiable factor, one case between doctors and in one case between health professionals and the woman.

In six cases, 14 minor modifiable factors were identified in relation to communication; four between doctors and midwives, three between doctors, three between departments and specialities, two between hospitals and one found between health professionals and the woman and one between a nurses and doctors.

Clinical review highest level of concern: Communication Between departments and or specialists

The breakdown of modifiable factors is included in the table below:

Category	Factors			
Diagnosis of a High Risk Status	Major	Minor	Wider Learning	Sub total
Delay in diagnosis or recognition of high-risk status	7		1	8
Delay in recognition of abnormal signs	5	1	1	7
Failure to recognise abnormal vital signs			1	1
Delay in checking investigations		1	1	2
Failure to order or check investigations	4	1	1	6
Inadequate monitoring of fetal growth	2		2	4
Delay in recognising surgical complications	4			4
Failure to recognise surgical complications	2			2
Total	24	3	0	27
Treatment	Major	Minor	Wider Learning	Sub total
No plan of care	4	6	1	11
Delay in treatment	3	9		12
Failure to act on a high risk situation	3	3	1	7
Failure to treat		5	1	6
Failure to treat blood pressure		1		1
Inappropriate treatment	1	1	2	4
Total	11	25	5	41
Clinical Leadership	Major	Minor	Wider Learning	Sub total
Failure to consult a superior	4	4		8
Failure to check on work of a more junior member	3	1	1	5
Inappropriate grade of staff		3	3	6
Other		3		3
Total	7	11	4	22

Communication	Major	Minor	Wider Learning	Sub total
Between doctors	1	3	1	5
Between midwives and doctors		4	3	7
Between nursing and doctors		1		1
Between departments /specialists	2	3	3	8
Between hospitals		2		2
Between health professional and woman	1	1	5	7
Total	4	14	12	30

More detailed information on the other modifiable factors can be found at *Appendix C*.

Level of Review by the Health Board

An internal review was undertaken in 13 of the 28 cases in this category. Clinical reviewers agreed with the findings in seven of these reviews. Of the 19 women where there were major modifiable factors identified, 12 cases had an internal review and a serious incident investigation was conducted in four cases.

4 WHAT MUST BE LEARNT

The following lessons were identified by the clinical review teams for the Health Board to take forward:

1. Diagnosis of high risk status:

- The important of situational awareness (Each Baby Counts 2015).
- Knowledge and skills to recognise and respond to clinical deterioration including identifying and interpreting signs and symptoms, abnormal vital signs and initiating early interventions. This is critical for the prevention and treatment of Sepsis.
- Use and completion of tools such as MEOWS in a timely manner.
- Provision of clear guidance and processes to support diagnosis and management of Placenta praevia/accrete.

2. Treatment:

- The importance of holistic care.
- Timely treatment of Sepsis.
- Evidence-based knowledge and skills to maintain surgical haemostasis.
- The importance of effective responsive radiology services.

3. Clinical Leadership:

- Multidisciplinary working and involvement in high-risk cases and situations.
- Consultant presence and oversight in complex high-risk situations.
- Clear guidance and processes for escalation of concerns at all levels.

4. Communication:

- Multidisciplinary working - particularly in relation to smoking cessation.
- The importance of appropriate postnatal debrief.
- The impact of mother's perceptions of staff's view of mental health.
- The need for appropriate debrief by a senior obstetrician.
- The importance of appropriate and timely handover to community midwifery teams.
- Liaison with health visiting teams by neonatal unit teams to highlight any maternal risk factors and discharge.
- Multidisciplinary approach to care planning and delivery should be implemented.

5 CONCLUSION

This review clearly highlights deficiencies in care from a clinical perspective and importantly from the perspective of women and families. The outcome for a significant number of women could have been different and the impact for women and families on their physical and emotional recovery has been profound.

Disappointingly these deficiencies also mirror those highlighted in previous national maternity care reports. This includes *Saving Lives, Improving Mothers' Care* which was published by MBRRACE-UK in 2018 and can be accessed [here](#). The purpose of these reports is to ensure that learning is shared from the care experienced by women and families and to prevent the reoccurrence of service deficiencies. It is clear from the emerging findings from the Clinical Review Programme that the Health Board had not embedded the lessons emerging from national reports nor best practice within its organisational culture and operating practices at the time that these episodes of care occurred.

The three areas identified by the clinical review teams as most frequently having an impact on the outcome or experience of women and their babies were the ability to diagnose women's high-risk status, the subsequent treatment provided and clinical leadership.

All clinicians are required to have the appropriate knowledge and skills to be able to identify the clinical risk status of each woman under their care when they first access maternity services to ensure they are given the most appropriate care, by an appropriate healthcare professional. The review found that on a number of occasions, the high-risk status was not identified at the beginning of the woman's antenatal care and this resulted in some women not commencing the most appropriate clinical pathway for their level of risk.

This assessment of clinical risk should be reviewed throughout the pregnancy to ensure that if the level of risk changes, referral is made to the most suitably qualified clinician to ensure that the most appropriate care and treatment is given in a timely manner. The review found that there were a number of opportunities to identify a change in the level of risk during the pregnancy, birth or following birth that were missed by the multidisciplinary team of clinicians. This resulted in a delay in referral to a more senior clinician with the appropriate level of experience.

The importance of multidisciplinary teams working together to care for women and their babies is vital in order to provide a safe level of care. This is especially important in high-risk cases where a number of professionals are involved in providing care. There should be a process in place to enable a clinician to escalate any concerns they may have regarding the condition of a woman and/or her baby to ensure care is given by the most experienced member of the team.

The review found that although there was an escalation process in place, there were missed opportunities for a more senior clinician to be present either before, during or after birth to ensure that a plan of care was made which was appropriate to the clinical situation.

Care and treatment should be based on local and national guidelines founded on the best available evidence providing recommendations on how healthcare professionals should care for people with specific conditions.

It is important that local guidelines reflect that treatment is based on this best available evidence and that these guidelines are up to date and followed by all clinicians. The review findings indicated that there were times when the clinical guidelines in place were not followed resulting in care not being delivered according to best practice.

6 WHAT NEXT?

The Panel has now completed the review, analysis and feedback processes for cases within the maternal mortality and morbidity categories. Attention will now turn to the stillbirth category. This involves the review of 64 episodes of care provided between 01 January 2016 and 30 September 2018¹ where the baby sadly was stillborn. Not only is this a substantially larger cohort than the maternal category, it will inevitably be more emotive and more poignant given that all of the women and families involved in these episodes of care suffered the loss of a baby.

The current position is that the majority of the individual reviews in the stillbirth category have been completed and the analysis of the findings is about to commence. The next steps will be the validation and quality assurance processes followed by the preparation of personalised feedback for women and families which is a time consuming and necessarily pain-staking process.

It is anticipated that letters will be sent out to women and families in the Spring of 2021 and the emerging findings from the stillbirth category will be reported upon by way of the publication of a second thematic report early in the Summer of 2021.

In the background, the clinical review teams have commenced work on the neonatal mortality and morbidity category and that work will continue through the first half of 2021. A more detailed assessment of the progress which is being made in this category and the likely timescales for completion will be included within the Panel's second thematic report.

Once all three categories within the 2016-2018 look-back have been completed and publicly reported on, the Panel anticipates publishing an overarching thematic report which will seek to draw together the learning to be taken forward by the Health Board as well as make any recommendations for learning on an all-Wales basis.

¹ Although the majority of the episodes of care which are being reviewed were provided during that period, a small number were not. That was either because the case is a self-referral which fitted the inclusion criteria or because the mother had more than one pregnancy and it is considered appropriate to review their individual episodes of care at the same time.

Clinical Review Assessment Tool

Case reference:

Please add the name and profession of all reviewers:

Name of designated lead reviewer:

Please provide a brief overview of the case:

1. Were there modifiable factors present in this case?

- Yes
- No → *If no, please go to Section 15*

2. Please tick the category for each factor present in this case (you may tick more than one).

- Pre-pregnancy or preconception care → *Go to Section 3*
- Assessment or point of entry to care → *Go to Section 4*
- Diagnosis or in the recognition of high-risk status → *Go to Section 5*
- Referral to a specialist → *Go to Section 6*
- Treatment → *Go to Section 7*
- Clinical leadership → *Go to Section 8*
- Education, Knowledge, Training → *Go to Section 9*
- Documentation → *Go to Section 10*
- Discharge or transfer from care → *Go to Section 11*
- Communication → *Go to Section 12*
- Policies and procedures → *Go to Section 13*
- Woman and her family → *Go to Section 14*

FACTORS RELATED TO HEALTHCARE PROFESSIONALS

Pre-pregnancy or preconception care

3. Was there an avoidable factor / event during pre-pregnancy or preconception care?

Yes

No

3a. If yes, then please tick each relevant factor or event.

Professional failed to provide pre-pregnancy counselling

Professional failed to get complete medical history

Other pre-pregnancy or preconception issue (*please specify*)

3b. Description of relevant issue.

3c. Were there national guidelines/standards related to the relevant factor or event?

Yes No

3d. If yes, were they followed?

Yes No

3e. Please note the relevant guidelines or standards.

3f. Please note the significance of this factor or event.

Major

Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

Minor

Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

Wider Learning

Although lessons can be learned, it did not affect the eventual outcome.

3g. Please note the main clinician or health care professional responsible for this factor or event.

- GP
- Hospital Midwife
- Community Midwife
- Obstetrician
- Anaesthetist
- A & E physician
- Psychiatrist
- Ambulance paramedic
- ICU physician
- Nurse
- Other (*please specify*)

3h. Please designate the status or grade of the main clinician or health care professional responsible for this factor or event.

Assessment or point of entry to care

4. Was there an avoidable factor / event during assessment or point of entry to care?

- Yes
- No

4a. If yes, then please tick each relevant factor or event.

- Mother was denied access to care or appointment
- Professional failed to offer preventative treatment
- Professional delayed assessment/evaluation of patient
- Professional failed to get complete medical history
- Other assessment or point of entry to care issue (*please specify*)

4b. Description of relevant issue.

4c. Were there national guidelines/standards related to the relevant factor or event?

- Yes No

4d. If yes, were they followed?

Yes No

4e. Please note the relevant guidelines or standards.

4f. Please note the significance of this factor or event.

Major

Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

Minor

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4g. Please note the main clinician or healthcare professional responsible for this factor or event.

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- Hospital Midwife
- Community Midwife
- Obstetrician
- Anaesthetist
- A & E physician
- Psychiatrist
- Ambulance paramedic
- ICU physician
- Nurse
- Other (*please specify*)

4h. Please designate the status or grade of the main clinician or healthcare professional responsible for this factor or event.

Diagnosis or in the recognition of high-risk status

5. Was there an avoidable factor / event during the patient's diagnosis or in the recognition of high-risk status at any stage?

- Yes
- No

5a. If yes, then please tick each relevant factor or event.

- Inappropriate diagnosis or categorisation of risk status
- Inadequate monitoring of fetal growth
- Inadequate fetal heart rate monitoring during labour
- Delay in diagnosis or recognition of high-risk status
- Delay in ordering or checking investigations
- Delay in recognition of abnormal vitals
- Delay in recognition of surgical complications
- Other delay (*please specify*)
- Failure in recognition of high-risk status (including failure to recognise intrauterine growth restriction)
- Failure in ordering or checking investigations (including failure to do or to repeat glucose tolerance test)
- Failure in recognition of abnormal vitals
- Failure in recognition of surgical complications
- Other failure (*please specify*)

5b. Description of relevant issue.

5c. Were there national guidelines/standards related to the relevant factor or event?

- Yes No

5d. If yes, were they followed?

- Yes No

5e. Please note the relevant guidelines or standards.

5f. Please note the significance of this factor or event.

Major

Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

Minor

Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

Wider Learning

Although lessons can be learned, it did not affect the eventual outcome.

5g. Please note the main clinician or healthcare professional responsible for this factor or event.

- GP
- Hospital Midwife
- Community Midwife
- Obstetrician
- Anaesthetist
- A & E physician
- Psychiatrist
- Ambulance paramedic
- ICU physician
- Nurse
- Other (*please specify*)

5h. Please designate the status or grade of the main clinician or healthcare professional responsible for this factor or event.

Referral to a specialist

6. Was there an avoidable factor/event regarding the referral to a specialist?

- Yes
- No

6a. If yes, then please tick each relevant factor or event.

- Delay in referral
- Failure to refer
- Appropriate person was not available or did not respond
- Services not available

6b. Description of relevant issue.

6c. Were there national guidelines/standards related to the relevant factor or event?

- Yes No

6d. If yes, were they followed?

- Yes No

6e. Please note the relevant guidelines or standards.

6f. Please note the significance of this factor or event.

Major

Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

Minor

Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

Wider Learning

Although lessons can be learned, it did not affect the eventual outcome.

6g. Please note the main clinician or health care professional responsible for this factor or event.

- GP
- Hospital Midwife
- Community Midwife
- Obstetrician
- Anaesthetist
- A & E physician
- Psychiatrist

- Ambulance paramedic
- ICU physician
- Nurse
- Other (*please specify*)

6h. Please designate the status or grade of the main clinician or healthcare professional responsible for this factor or event.

Treatment

7. Was there an avoidable factor/event regarding treatment?

- Yes
- No

7a. If yes, then please tick each relevant factor or event.

- No plan of care/management
- Delay in treatment (including delayed operation)
- Inappropriate treatment
- Poor diabetic management
- Failure to treat. *If yes, then was the failure one of the following:*
- Failure to act on high-risk situation/history
- Failure to act on intra-uterine growth restriction
- Failure to act on decreased fetal movements
- Failure to act on raised blood pressure and/or proteinuria
- Failure to act on suspicious antenatal cardiograph
- Failure to resuscitate a newborn

7b. Description of relevant issue.

7c. Were there national guidelines/standards related to the relevant factor or event?

- Yes No

7d. If yes, were they followed?

- Yes No

7e. Please note the relevant guidelines or standards.

7f. Please note the significance of this factor or event.

Major

Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

Minor

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Wider Learning

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7g. Please note the main clinician or healthcare professional responsible for this factor or event.

GP

Hospital Midwife

Community Midwife

Obstetrician

Anaesthetist

A & E physician

Psychiatrist

Ambulance paramedic

ICU physician

Nurse

Other (*please specify*)

7h. Please designate the status or grade of the main clinician or healthcare professional responsible for this factor or event.

Clinical leadership

8. Was there an avoidable factor/event regarding clinical leadership?

Yes

No

8a. If yes, then please tick each relevant factor or event.

- Fail to check on junior's work (e.g., senior did not attend)
- Fail to consult superior
- Inappropriate grade of staff involved in care

8b. Description of relevant issue.

8c. Were there national guidelines/standards related to the relevant factor or event?

- Yes No

8d. If yes, were they followed?

- Yes No

8e. Please note the relevant guidelines or standards.

8f. Please note the significance of this factor or event.

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- Hospital Midwife
- Community Midwife
- Obstetrician
- Anaesthetist
- A & E physician
- Psychiatrist
- Ambulance paramedic

- ICU physician
- Nurse
- Other (*please specify*)

8h. Please designate the status or grade of the main clinician or healthcare professional responsible for this factor or event.

Education, knowledge and training

9. Was there an avoidable factor / event regarding education of a health professional?

- Yes
- No

9a. If yes, then please tick the relevant factor or event.

- Lack of knowledge or training

9b. Description of relevant issue.

9c. Were there national guidelines/standards related to the relevant factor or event?

- Yes No

9d. If yes, were they followed?

- Yes No

9e. Please note the relevant guidelines or standards.

9f. Please note the significance of this factor or event.

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Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

Minor

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9g. Please note the main clinician or healthcare professional responsible for this factor or event.

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- Community Midwife
- Obstetrician
- Anaesthetist
- A & E physician
- Psychiatrist
- Ambulance paramedic
- ICU physician
- Nurse
- Other (*please specify*)

9h. Please designate the status or grade of the main clinician or healthcare professional responsible for this factor or event.

Documentation

10. Was there an avoidable factor/event regarding documentation?

- Yes
- No

10a. If yes, then please tick each relevant factor or event.

- Poor documentation
- Failure to document/incomplete records

10b. Description of relevant issue.

10c. Were there national guidelines/standards related to the relevant factor or event?

- Yes No

10d. If yes, were they followed?

- Yes No

10e. Please note the relevant guidelines or standards.

10f. Please note the significance of this factor or event.

Major

Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

Minor

Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

Wider Learning

Although lessons can be learned, it did not affect the eventual outcome.

10g. Please note the main clinician or healthcare professional responsible for this factor or event.

GP

Hospital Midwife

Community Midwife

Obstetrician

Anaesthetist

A & E physician

Psychiatrist

Ambulance paramedic

ICU physician

Nurse

Other (*please specify*)

10h. Please designate the status or grade of the main clinician or healthcare professional responsible for this factor or event.

Discharge or transfer from care

11. Was there an avoidable factor/event regarding during the post-delivery or discharge period?

Yes

No

11a. If yes, then please tick each relevant factor or event.

- Inappropriate transfer home
- Inappropriate discharge from care
- Failure to counsel patient
- Failure to arrange appropriate ongoing treatment / care
- Failure to follow up after transfer home
- Inadequate screening following a stillbirth
- Problems with the post mortem examination including failure to send samples
- Insufficient bereavement support

11b. Description of relevant issue.

11c. Were there national guidelines/standards related to the relevant factor or event?

- Yes No

11d. If yes, were they followed?

- Yes No

11e. Please note the relevant guidelines or standards.

11f. Please note the significance of this factor or event.

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Minor

Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

Wider Learning

Although lessons can be learned, it did not affect the eventual outcome.

11g. Please note the main clinician or healthcare professional responsible for this factor or event.

- GP
- Hospital Midwife
- Community Midwife

- Obstetrician
- Anaesthetist
- A & E physician
- Psychiatrist
- Ambulance paramedic
- ICU physician
- Nurse
- Other (*please specify*)

11h. Please designate the status or grade of the main clinician or healthcare professional responsible for this factor or event.

FACTORS RELATED TO SERVICES

Communication

12. Was there an avoidable factor/event due to communication problems?

- Yes
- No

12a. If yes, then please tick each relevant factor or event.

- Between doctors
- Between midwives and doctors
- Between nursing and doctors
- Between departments / specialists
- Between hospitals
- Between health professional and woman (including importance of changes in fetal movement not explained to woman)

12b. Description of relevant issue.

12c. Were there national guidelines/standards related to the relevant factor or event?

- Yes No

12d. If yes, were they followed?

Yes No

12e. Please note the relevant guidelines or standards.

12f. Please note the significance of this factor or event.

Major

Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

Minor

Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

Wider Learning

Although lessons can be learned, it did not affect the eventual outcome.

Policy or procedure problems

13. Was there an avoidable factor/event due to policy or procedure problems?

Yes

No

13a. If yes, then please tick each relevant factor or event.

Regarding lab facilities or results

Regarding oversight of others (e.g., no senior on call)

Regarding scheduling and assessment

Regarding emergency preparedness (e.g., ICU full or too distant, lack of theatre, lack of blood)

Regarding patient education

Regarding availability of records (e.g., at time of birth)

Regarding staff workload

Other (*please specify*)

13b. Description of relevant issue.

13c. Were there national guidelines/standards related to the relevant factor or event?

Yes No

13d. Please note the relevant guidelines or standards.

13e. Please note the significance of this factor or event.

Major

Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

Minor

Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

Wider Learning

Although lessons can be learned, it did not affect the eventual outcome.

FACTORS RELATED TO THE WOMAN AND HER FAMILY

14. Was there an avoidable factor/event due to the woman and her family?

Yes

No

14a. If yes, then please tick each relevant factor or event.

Non-compliance with medical advice (e.g., refused treatment, refused blood)

Failure to seek care (including failure to report decreased fetal movements until after delivery)

Failure to attend scheduled care, including inadequate antenatal care

Substance misuse

Other (*please specify*)

14b. Description of relevant issue.

14c. Please note the significance of this factor or event.

Major

Factor contributed significantly to the death. Different management would reasonably have been expected to alter the outcome.

Minor

Factor was a relevant contributory factor. Different management might have made a difference, but survival was unlikely in any case.

Wider Learning

Although lessons can be learned, it did not affect the eventual outcome.

ASSESSMENT OF CARE

15. Does the panel think overall care of the mother and baby was optimal, adequate or poor?

Antenatal Care	<input type="checkbox"/> Optimal	<input type="checkbox"/> Adequate	<input type="checkbox"/> Poor	<input type="checkbox"/> Insufficient information in notes
Intrapartum Care	<input type="checkbox"/> Optimal	<input type="checkbox"/> Adequate	<input type="checkbox"/> Poor	<input type="checkbox"/> Insufficient information in notes
Postpartum care	<input type="checkbox"/> Optimal	<input type="checkbox"/> Adequate	<input type="checkbox"/> Poor	<input type="checkbox"/> Insufficient information in notes

15a. Please highlight any particular instances of optimal care or care that went above and beyond expectations.

RECOMMENDATIONS AND LEARNING POINTS

16. Please summarise recommendations and learning points illustrated by this case.

INTERNAL REVIEWS

17. Was there a Serious Untoward Incident (SUI) triggered?

Yes No

18. Was there a Health Board internal review?

Yes No

18a. What was the conclusion of the internal review?

18b. Does the panel agree with the conclusion of the internal review?

Yes No

18c. Please specify.

WOMAN AND FAMILY'S QUESTIONS

Please provide a response to the woman and family's questions:

Women's and Families' Experience Pro Forma

INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL

CLINICAL REVIEWS: WOMEN AND THEIR FAMILIES' EXPERIENCE

We would like to have an understanding of how you felt about the care you received throughout your pregnancy. We want to do this to identify what needs to improve both in terms of the clinical care you may have received but also how you felt you were treated and your overall experience in using the services. It will also be important for us to understand what may have gone well so we can identify and share this to drive learning and improvement.

If you had any concerns which you feel have not been answered this is an opportunity to let us know about those. In order to ensure we capture all the information we need we have developed this form but if there is anything you want to add then please do so in the section provided.

We will share this information with the clinical reviewers who will be looking at your individual case. The reviewers will try their best to answer any outstanding issues you may have regarding your clinical care. By this we mean, issues relating to your pregnancy which may have been linked to the actions or inactions of maternity staff.

The reviewers will not be able to answer questions which do not relate to the clinical aspects of your care, for example, issues around complaints handling. However, it is vital that this information is still captured and fed into our overall improvement process. We want to ensure we use your experiences to shape the services of the future.

Independent support is available to help you complete this form. Please see attached information from the Community Health Council's Chief Officer.

Is there anything you would like to highlight to the review teams regarding your clinical care?

How do you feel about the care you received throughout your pregnancy and afterwards?

What do you think was good about the care and support you received?

Was there any aspect of your care and support that did not go well?

What do you think could have been improved or changed, and if so how?

Did you always feel involved in decisions about your care?

Please tell us more about that...

Did you always feel that you had enough time with your midwife or doctor to talk through decisions and concerns at any time?

Please tell us more about that...

Did you feel after talking through your decisions and concerns they were listened to and acted on?

Please describe your experience...

What did you think about the information you were given during pregnancy (i.e. did it give you the information you needed in a way you could understand?)

Were you given information about how to raise concerns and did you know who to talk to?

If you raised concerns what did you think about the way they were looked at, the explanation and response?

Is there anything that could have been done differently to improve the response?

If you had any concerns are there any outstanding questions that you feel you still need answers to? If so please tell us what they are?

THANK YOU FOR TAKING THE TIME TO SHARE YOUR EXPERIENCE WITH US. WHEN WE HAVE COMPLETED THE FIRST PHASE OF CLINICAL REVIEWS WE WILL BE PUBLISHING A REPORT ON THE OVERALL THEMES AND RECOMMENDED LEARNING. WE WOULD LIKE TO INCLUDE REFERENCES TO YOUR EXPERIENCE IN THIS REPORT. WE WOULD ALSO LIKE TO USE YOUR EXPERIENCE TO ENABLE THE HEALTH BOARD TO DEVELOP EDUCATIONAL TOOLS SUCH AS A TRAINING VIDEO OR PATIENT STORY. WE WILL ENSURE THAT YOUR INFORMATION REMAINS COMPLETELY ANONYMOUSED. IF YOU ARE HAPPY FOR THIS INFORMATION TO BE USED FOR THE PURPOSES LISTED ABOVE IN ADDITION TO THE CLINICAL REVIEW OF YOUR CASE PLEASE SIGN BELOW:

SIGNATURE:

DATE:

PLEASE SEND THE COMPLETED FORM TO OUR MAILBOX: oversightpanel.maternity@gov.wales

Occurrence of Significance against Modifiable Factors and Sub-Categories

Modifiable Factors	Significance			
	Major	Minor	Wider Learning	Sub total
Pre-pregnancy or preconception				
Professional failed to provide pre-pregnancy counselling	2		2	4
Other pre-pregnancy or preconception issue	2			4
Assessment or point of entry to care				
Professional failed to offer preventative treatment	2		2	4
Professional delayed assessment/evaluation of patient	5	2	1	8
Professional failed to get complete medical history	3	1	4	7
Other assessment or point of entry to care issue	2	2	2	6
Diagnosis of a High Risk Status				
Delay in diagnosis or recognition of high-risk status	7		1	8
Delay in recognition of abnormal signs	5	1	1	7
Failure to recognise abnormal vital signs			1	1
Delay in checking investigations		1	1	2
Failure to order or check investigations	4	1	1	6
Inadequate monitoring of fetal growth	2		2	4
Delay in recognising surgical complications	4			4
Failure to recognise surgical complications	2			2
Treatment				
No plan of care	4	6	1	11
Delay in treatment	3	9		12
Failure to act on a high risk situation	3	3	1	7
Failure to treat		5	1	6
Failure to treat blood pressure		1		1
Inappropriate treatment	1	1	2	4
Referral to Specialist				
Failure to refer	1	3	1	5
Services not available	3	2	1	6
Appropriate person not available	2	2	1	5
Delay in referral	2	1	2	5
Clinical Leadership				
Failure to consult a superior	4	4		8
Failure to check on work of a more junior member	3	1	1	5
Inappropriate grade of staff		3	3	6
Other		3		3

Education, Knowledge, Training				
Lack of knowledge or training	5	2	1	8
Documentation				
Poor documentation	9	8	3	20
Failure to document / incomplete records	11	4	5	20
Discharge or transfer from care				
Inappropriate discharge from care	1			1
Failure to counsel patient	2		3	5
Failure to arrange appropriate ongoing treatment / care	2	1	2	5
Failure to follow up after transfer home	1		4	5
Insufficient bereavement support		1		1
Communication				
Between doctors	5	3	1	9
Between midwives and doctors	7	4	3	14
Between nursing and doctors	1	1		2
Between departments /specialists	6	4	2	12
Between hospitals	4	2		6
Between health professional and woman (including importance of changes in fetal movement not explained to woman)	8	1	5	14
Policies and procedures				
Regarding lab facilities or results	3			3
Regarding scheduling and assessment	3	2		5
Regarding emergency preparedness (e.g. ICU full or too distant, lack of theatre, lack of blood)	5	1	1	7
Regarding patient education			2	2
Regarding availability of records (e.g. at time of birth)	1	1	1	3
Regarding staff workload	2	1	3	6
Other	2	2		4
Woman and her family				
Medical advice declined (e.g. refused treatment, refused blood)	1			1
Delay in seeking care or did not seek care (including failure to report decreased fetal movements until after delivery)	1			1
Delay in attending scheduled care or did not attend scheduled care, including inadequate antenatal care	1			1
Smoker		1		1
Other	1			1

