Maternity Services Update
Health Inspectorate Wales (HIW)
Royal College of Maternity Services
Deanery, Maternity and Neonatal Safety Support Programme (MatneoSSP)
Mothers and Babies Reducing Risk through Audit and Confidential Enquiries (MBRRACE) December 2022

Situation

A seven minute briefing to cover the areas as there is a golden thread that runs through each of these areas for assurance (Appendix 1).

- Quality of Womens Experience
- Delivery of Safe Effective Care
- Quality of Management and Leadership

Maternity Update

HIW, RCM, Deanery, MatneoSSP, MBRRACE, Experience

Maternity services 7 Minute Briefing

December 2022

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

1) What is the golden thread

HIW Maternity Services Inspection 28-30 Nov 2022

- Quality of Womens Experience
- Delivery of Safe Effective Care
- Quality of Management and Leadership

RCM Survey in the Summer

- Quality of Management and Leadership

Deanery

- Delivery of Safe Effective Care
- Quality of Management and Leadership

MatneoSSP

- Quality of Womens Experience
- Delivery of Safe Effective Care

MBRRACE

- Quality of Womens Experience
- Delivery of Safe Effective Care

2) What are the findings, conclusions and essential actions

The findings and recommendations include.

HIW

- Good governance observed
- Visible compassionate and accessible senior leadership
- Women and families described the care as excellent although there were times of delayed pain relief on the PN ward
- PADR and medical training compliance was an area for improvement
- Senior Medical leadership required improvement in timely attendance
- Staff felt safe to escalate
- Staff were observed to provide kind and compassionate care
- Staff were happy and proud of the quality of the care they provide.
- RCM Caring 4 You Charter
- Directorate wide Culture Action Plan
- MATneoSSP Local Champion recruited
- MBRRACE Stillbirth SA 3.17 – NND 0.99 – Extended NND 4.14

3) Investigations

Good governance and clinical curiosity leading to appreciative enquiry to maximise the review and opportunity for learning when events occur.

Implementation of learning via the governance routes (Guidelines, Lunch and Learn, Safety Boards, Newsletters, Labour Ward Forum, Risk and Governance meeting, CTG reflections sessions and the CTG Chronicles)

Audit and monitoring to ensure no repeats of concerns identified – mitigate against recurrence

Actively seeking out both staff and user feedback to support further learning and the ability to iterate based on local needs.

4) Examples for Learning and Improvement

Governance QI Project aiming to improve psychological safety in teams and encourage reporting of concerns

Clinical Supervisors for Midwives Fluid Balance QI project aiming to improve compliance with the tools to improve outcomes for women

Co-produced suite of information leaflets and videos and resources for families

QI project aiming to improve the use of language in Maternity services to align to the UK Re-birth Project – promote inclusivity

EQIP Induction of Labour project aiming to streamline and improve allocation of complexity of cases booked for induction of labour

CTG reflection meetings – supporting everyone to have a voice and speak up, voting system developed enabling involvement of the team

IOL research project

5) Hearing the Voices of Staff

People and Culture Team directorate wide culture action plan

Senior Team visibility and open-door opportunities for staff to raise concerns

Deanery action plan and improvement programme

Apology – this goes a long way in acknowledging impact on staff

MDT training and drills to support creation of psychological safety

Celebrate success encourage innovation, find staff passion to support creating personal and team development and succession planning

Wellbeing Committee of the staff for the staff

Maternity and Trainees Partnership Forums

6) Supporting the families

- ✓ The voices of the families are central to this review
- ✓ National PMRT
- ✓ Birth Reflections Clinic
- ✓ Early adoption of Duty of Candour and meeting with the families to apologise
- ✓ Working with the local Citizens Voices
- ✓ Named Health Board Contact
- ✓ Service User Engagement to develop resources and HB guidelines
- ✓ Maternity Voices Partnership Programe
- ✓ Local Surveys

7) What next?

MatneoSSP to support learning from a number of key reviews of Maternity Services across the UK, no new themes emerging so focus on system led improvement based on local intelligence to create improvements in care and outcomes.

Working with Welsh Government to develop a quality framework and quality statements for Maternity Services in Wales – 'What does good look like'

Implementing the Digital Cymru programme next year to support national benchmarking, quality assurance and the ambition to be a data driven service based on local and national intelligence – local development of a live dashboard using key national data sets to support understanding of how we are doing and support further work for improvement

To use local national and peer reviews (i.e. HIW, CHC, Maternity and Neonatal Network) to inform, refresh and create opportunities to improve

Implementation of the SSSA – future midwife standards to support future proofing of maternity services

Birthrate Plus staffing modelling review

Collaboration between Swansea Bay and Swansea University in delivering the CNO award winning programme of supporting physiological birth

Look at some of the excellent work of our teams for nomination for RCM awards

Commencing the VTE QI project and pathways supporting accuracy in risk assessment and redirecting pregnant DVT assessments away from ED

Recommendation

For QSEC to take an assurance from the presentation provided.

For QSEC to be aware they may be a further requirement / recommendation from HIW when the draft report is received regarding the need for specialist midwife in Fetal Surveillance.

Maternity Update

HIW, RCM, Deanery, MatneoSSP, MBRRACE, Experience

Maternity services 7 Minute Briefing

December 2022

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

1) What is the golden thread

HIW Maternity Services Inspection 28-30 Nov 2022

- Quality of Womens Experience
- Delivery of Safe Effective Care
- Quality of Management and Leadership

RCM Survey in the Summer

- Quality of Management and Leadership

Deanery

- Delivery of Safe Effective Care
- Quality of Management and Leadership

MatneoSSP

- Quality of Womens Experience
- Delivery of Safe Effective Care

MBRRACE

- Quality of Womens Experience
- Delivery of Safe Effective Care

2) What are the findings, conclusions and essential actions

The findings and recommendations include.

HIW

- Good governance observed
- Visible compassionate and accessible senior leadership
- Women and families described the care as excellent although there were times of delayed pain relief on the PN ward
- PADR and medical training compliance was an area for improvement
- Senior Medical leadership required improvement in timely attendance
- Staff felt safe to escalate
- Staff were observed to provide kind and compassionate care
- Staff were happy and proud of the quality of the care they provide.
- RCM Caring 4 You Charter
- Directorate wide Culture Action Plan
- Local Champion recruited
- MBRRACE Stillbirth SA 3.17 – NND 0.99 – Extended NND 4.14

3) Investigations

Good governance and clinical curiosity leading to appreciative enquiry to maximise the review and opportunity for learning when events occur.

Implementation of learning via the governance routes (Guidelines, Lunch and Learn, Safety Boards, Newsletters, Labour Ward Forum, Risk and Governance meeting, CTG reflections sessions and the CTG Chronicles)

Audit and monitoring to ensure no repeats of concerns identified – mitigate against recurrence

Actively seeking out both staff and user feedback to support further learning and the ability to iterate based on local needs.

4) Examples for Learning and Improvement

Governance QI Project aiming to improve psychological safety in teams and encourage reporting of concerns

Clinical Supervisors for Midwives Fluid Balance QI project aiming to improve compliance with the tools to improve outcomes for women

Co-produced suite of information leaflets and videos and resources for families

QI project aiming to improve the use of language in Maternity services to align to the UK Re-birth Project – promote inclusivity

EQIP Induction of Labour project aiming to streamline and improve allocation of complexity of cases booked for induction of labour

CTG reflection meetings – supporting everyone to have a voice and speak up, voting system developed enabling involvement of the team

IOL research project

5) Hearing the Voices of Staff

People and Culture Team directorate wide culture action plan

Senior Team visibility and open-door opportunities for staff to raise concerns

Deanery action plan and improvement programme

Apology – this goes a long way in acknowledging impact on staff

MDT training and drills to support creation of psychological safety

Celebrate success encourage innovation, find staff passion to support creating personal and team development and succession planning

Wellbeing Committee of the staff for the staff

Maternity and Trainees Partnership Forums

6) Supporting the families

- ✓ The voices of the families are central to this review
- ✓ National PMRT
- ✓ Birth Reflections Clinic
- ✓ Early adoption of Duty of Candour and meeting with the families to apologise
- ✓ Working with the local Citizens Voices
- ✓ Named Health Board Contact
- ✓ Service User Engagement to develop resources and HB guidelines
- ✓ Maternity Voices Partnership Programe
- ✓ Local Surveys

7) What next?

MatneoSSP to support learning from a number of key reviews of Maternity Services across the UK, no new themes emerging so focus on system led improvement based on local intelligence to create improvements in care and outcomes.

Working with Welsh Government to develop a quality framework and quality statements for Maternity Services in Wales – 'What does good look like'

Implementing the Digital Cymru programme next year to support national benchmarking, quality assurance and the ambition to be a data driven service based on local and national intelligence – local development of a live dashboard using key national data sets to support understanding of how we are doing and support further work for improvement

To use local national and peer reviews (i.e. HIW, CHC, Maternity and Neonatal Network) to inform, refresh and create opportunities to improve

Implementation of the SSSA – future midwife standards to support future proofing of maternity services

Birthrate Plus staffing modelling review

Collaboration between Swansea Bay and Swansea University in delivering the CNO award winning programme of supporting physiological birth

Look at some of the excellent work of our teams for nomination for RCM awards

Commencing the VTE QI project and pathways supporting accuracy in risk assessment and redirecting pregnant DVT assessments away from ED