HYWEL DDA UNIVERSITY HEALTH BOARD:

Ockenden Report
Community Health Council (CHC) Report
Welsh Branch Royal College of Midwives (RCM) Staff Survey

MATERNITY SERVICE UPDATE
June 2022

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

BACKGROUND

- Following the Health Board Quality and Safety Experience Committee Meeting in April 2022, Maternity Services were asked to provide an updated position against:
  - NHS England - Ockenden Report benchmarking
  - November 2021 CHC Survey Report
  - Updated against the actions taken in response the Welsh Branch Royal College of Midwives staff survey

Ockenden Report Recommendations

Overview of Report

- Review requested by Jeremy Hunt MP, commissioned by NHS Improvement to examine 23 cases of concern collated by parents of Kate Stanton-Davies and Pippa Griffiths who died in 2009 and 2016.
- 1,486 families cases were reviewed for the years between 2000 – 2019.
- The Terms of Reference include the Trusts internal investigations where they had occurred and the team were asked to consider external reports into the Trusts Maternity services over these years.
- Throughout the review the main focus was that those families impacted by the maternity services were heard.
- In addition was the importance of giving the staff the opportunity to be heard. 60 members of former staff were included in this review

Reports findings / recommendations

- Local Actions for Learning
  - 60 actions for learning were identified specifically for the Trust following the review of the 1,486 cases – the themes identified were:
    - Safe and Effective Care
    - Family Centred Care
    - Skilled Multi-professional Teams
    - Continuity of Carer
    - Sustainable Services and Workforce Planning
- Immediate and Essential Actions
  - 15 themed areas were identified for a national response to the Ockenden Report lead by NHS England and NHS Improvement England

1. Workforce Planning and Sustainability	8. Complex Antenatal Care
2. Safe Staffing	9. Preterm Birth
3. Escalation and Accountability	10. Labour and Birth
4. Clinical Governance and Leadership	11. Obstetric Anaesthesia
5. Incident Investigation and Complaints	12. Postnatal Care
6. Learning form Maternal Deaths	13. Bereavement Care
7. Multidisciplinary Training	14. Neonatal Care
	15. Supporting Families

WHAT DID WE DO?

- All Health Boards were asked to benchmark their Maternity Service , led by the Maternity and Neonatal Network and Welsh Government. An All Wales Assurance Framework document was provided and the Health Board were asked to report by exception areas identified for improvement.
- There was a detailed and multidisciplinary collaborative assessment of each of the recommendations
- A Red/ Amber/ Green (RAG) rating system was initiated for ease of use
- There were 15 recommendations that were RAG rated ‘amber’ indicating that there was work underway to progress these prior to benchmarking. One action was identified as red as tis requires a National Response and training programme.
- On the 7th July, the 7 Health Boards Maternity Services in Wales are attending a multidisciplinary workshop (each b is taking a team of 10 key stakeholders) to review each others exception reports to identify opportunities for learning and to commence the development of a Quality Assurance Indicators of what good looks like to support benchmarking against standards.

WHAT DID WE FIND?

Local Actions for Learning

Safe and Effective Care -37 recommendations

- 7 RAG rated as Amber – 1.1, 1.7, 1.9, 1.11, 1.15, 1.24,
  - 1.1 – National Maternity and Neonatal Safety Improvement Programme Patient Safety Specialist in post for each Health Board.
  - 1.7 - Midwifery, Neonatal and Obstetric co-leads for audit, clinical governance, mortality and morbidity
  - 1.9 – Support a full program of audit
  - 1.11 – Health Board should appoint a Lead Midwife and Lead Obstetrician for fetal surveillance
  - 1.15 – Process to facilitate a full Multi Disciplinary Team debrief following unexpected outcomes
  - 1.24 – Regional integration of maternal mental health services

Family Centred Care - 10 recommendations

- 2 RAG rated as Amber – 2.7, 2.8
  - 2.7 - Framework for Family Integrated Care
  - 2.8 - *Peer support networks should be developed for families when using and after discharge from the Neonatal Services.

* Although this requires the Maternity and Neonatal Network to support its development the Maternity Voices Partnership (MVP) will explore what can be done locally to support our families via a sub group of the MVP.

WHAT DID WE FIND?

Local Actions for Learning

Skilled Multi-professional Teams – 16 recs

- 5 RAG rated as Amber – 3.2, 3.3, 3.7, 3.10, 3.16
  - 3.2 – Midwifery Labour Ward (LW) co-ordinators must attend a full funded nationally recognised education module. Specialist post with an accompanying Job Description.
  - 3.3 – Newly appointed LW co-ordinators to receive an orientation package
  - 3.7 – Obstetric Consultant cover – review clinical timetable to ensure 12 hour cover per day on LW. Undertake a series of visits where extended Consultant LW cover has been implemented.
  - 3.10 – HB to allow adequate time for clinical leadership to function. Newly appointed band 7/8 midwives must be allocated a named experienced mentor for support.
  - 3.16 - Investment in neonatal nursing, part matron, part improvement and nurse in charge must be supernumerary, Advanced Nurse Practitioner should be expanded to ensure career progression. Nurse Consultant posts to be explored.

Continuity of Carer - 1 recs

- 1 RAG rated as Amber – 4.1
  - 4.1 - Continuity of carer achieved via community midwifery, unable to achieve this for acute admissions
  - 4.1 - Review of Obstetric clinics and rotas to ensure continuity within obstetric teams achieved.

WHAT DID WE FIND?

Local Actions for Learning

Sustainable Services and Workforce Planning – 16 recs

- 3 RAG rated as Amber – 5.6, 5.7, 5.12
  - 5.6 – Strategy in place to support succession planning programme for maternity workforce and development of future leaders and senior managers. Gap analysis of all leadership and management post in midwifery and obstetrics.
  - 5.7 – Obstetric anaesthetic guidance for the role of Consultants, SAS doctors and doctors in training. Full range of obstetric anaesthetic cover for LW, elective lists, teaching, training and governance activity. Competency required for Consultant staff who cover obstetric services out of hours who have no regular cover on obstetric commitments.
  - 5.12 – Ensure the appropriate level of breastfeeding advice, guidance and support is provided at all times.

Ockenden Next Steps

- Evidence has been provided to support current mitigation for areas graded Amber / Red.
- Further exploration on an All Wales basis on the 7th July with our colleagues across Wales as a Multi Disciplinary Team.
- All Wales Quality Assurance Framework to support benchmarking against an agreed standard to evidence the improvements made – required against the Ockenden Report.

Hywel Dda Maternity Services Community Health Council (CHC) Report November 2021

Maternity Services Response and Action Plan

Background and Actions

- November 2021 CHC Survey Report received for Hywel Dda University Health Board Maternity Services.
  - 13 areas for response identified. 6 areas outstanding for evidence of implementation.
    - Continuity of care – programme implemented, local audit to be undertaken to evidence impact of changes made, expected September 2022
    - First time mothers, information to support information requirements to prevent unnecessary worry – multiple actions to address the area of improvement, pivotal to the change is the redesign and implementation of ward based booklets which support orientation of what to expect from care to discharge. First draft is being consulted by the Multi Disciplinary Team. Anticipated sign off September 2022
    - Breast feeding support – discussions ongoing with Public Health Wales to determine pathways and funding to fully implement due to scale of the work required on an All Wales basis
    - Consistent, kind communication - improvement work undertaken, survey in progress to gauge women's experience of the required information, experience of care by maternity teams, early feedback is positive, expected July 2022
    - Information regarding discharge process – linked to ‘first time mothers’ improvement work – expected September 2022
    - Health visiting, strengthening consistency across the areas – this had been passed to the appropriate team for response.

Welsh Branch Royal Colleges Midwives Staff Survey Hywel Dda April 2022

Maternity Services Response and Actions

Background and Actions

- Staff Survey received in April 2022 – series of meeting held between HDUHB and the Chief Nursing Officer and stakeholders
- Action Plan developed in address the concerns raised:
    - Patient safety teams Patient Advice and Liaison Service – clinical interaction observation on the maternity wards. Early feedback is positive.
    - Culture and Relationship Teams - fortnightly schedule to visit the maternity teams, build relationships and support understanding the culture within which our clinicians - supporting the directorate to create a work programme to address the themes created.
    - Band 7 team have been added to the study day 'Making a difference'.
    - Working with HR and Organisational Development to create conflict resolution workshops to support the Band 7/ medical team develop skills to support staff.
    - Monthly listening events – the first was held on the 11th May 2022, this was well attended by midwives, HCA's student midwives - development of a Newsletter 'You said, We did' . This attended by the Directorate Triumvirate and clinical leads to support teams getting to know each other.
    - The survey was shared with the senior team and Band 7 team prior to a thematic feedback to staff in which the actions taken will be shared.
    - Support has been provided to those staff where individuals were identified
    - Wellbeing Wednesday working committee commenced is first planning meeting on 13th May to look at what support the staff would like to create 'Joy at Work'
    - Business case is being developed to explore employing a roster manager
    - Expanding the function of governance to upskill our teams. Demystify governance, make this everyone's business, increase reporting and creating greater capacity for systems learning to support psychological safety within the directorate.
    - A directorate wide approach is being delivered as we move to bringing together the varying disciplines within the directorate and create a one team approach to addressing the wellbeing of our staff.
    - Workshop event held on 18th May 2022 to explore workforce behaviour- multi-professional event
    - Obstetric Rota reviewed and found to be compliant with required 40 hours cover. The team are undertaking a review to explore a possible 60 hour rota (Ockenden rec).

QSEC Recommendation

- For Quality and Safety Experience Committee to receive assurance on progress with the recommendations following the Benchmarking Exercise into Maternity Services across Wales.