HYWEL DDA UNIVERSITY HEALTH BOARD:

Response to The Royal Colleges' Independent Review of Maternity Services at Cwm Taf University Health Board (CTMUHB)

MATERNITY SERVICE UPDATE
APRIL 2022

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

BACKGROUND

- Welsh Government commissioned a review of the Maternity Service provided by CTMUHB which was initially prompted by the discovery of under-reporting of serious incident cases.
- The review highlighted several concerns relating to staffing, clinical governance, effective clinical leadership and a blame culture that impacted staff confidence in reporting concerns.
- It raised significant concerns and questions about the effectiveness of wider Health Board (HB) leadership and governance.

WHAT DID THIS MEAN?

- The Maternity Service was placed under ‘special measures’
- In view of the high level of concern relating to the HB’s governance arrangements for quality, targeted intervention ensued.
- An Independent Oversight Panel (IMSOP) was commissioned
- Arrangements were put in place to seek assurance and improve the effectiveness of HB leadership and governance arrangements in CTMUHB
- Welsh Government sought immediate assurances from all HB’s in Wales
- HBs were to consider their own services in the context of the recommendations of the report and to provide assurance

RECOMMENDATIONS

There were 70 recommendations specified under the following 9 Terms of Reference (ToR):

- ToR 1: To review the current provision of care within maternity services in relation to national standards and indicators, as well as national reporting
- ToR 2: Assess the prevalence and effectiveness of a patient safety culture within maternity services
- ToR 3: Review the RCA investigation process, how Serious Incidents are identified, reported and investigated with the maternity services; how recommendations from investigations are acted upon by the maternity services; how processes ensure sharing of learning amongst clinical staff, senior management and stakeholders and whether there is clear evidence that learning is undertaken and embedded as a result of any incident or event.
- ToR 4: Review how through the governance framework the HB gains assurance of the quality and safety of maternity and neonatal services.
- ToR 5: Review the current midwife and obstetric workforce and staffing rotas in relation to safely delivering the current level of activity and clinical governance responsibilities.
- ToR 6: Review the working culture within maternity including inter-professional relationships, staff engagement and communication between health care professionals and their potential impact on improvement activities, patients' safety and outcomes.
- ToR 7: Identify the areas of leadership and governance that would benefit from further targeted development to secure and sustain future improvement and performance.
- ToR 8: Assess the level of patient engagement and involvement within the maternity services and determine if patient engagement is evident in all elements of planning and service provision. Assess whether services are patient centred, open and transparent
- ToR 9: Consider the appropriateness and effectiveness of the improvement actions already implemented by the HB.

WHAT DID WE DO?

- All HB's had a two week timescale to benchmark their Maternity Service , led by the Maternity and Neonatal Network. An All Wales Assurance Framework document was provided
- There was a detailed and collaborative assessment of each of the recommendations
- A Red/ Amber/ Green (RAG) rating system was initiated for ease of use
- There were 17 recommendations that were RAG rated 'amber' indicating that there was work underway to progress these prior to benchmarking
- Whilst there has been significant progress, despite the impact of the pandemic, there are 4 recommendations RAG rated amber, which require , renewed focus at HDUHB (7.2/7.3, 7.96, 7.32, 7.46)

WHAT DID WE FIND?

Recommendation 7.2

Identify nominated individuals (consultant obstetric lead and senior midwife) to ensure that all maternity unit guidelines:

- Are up to date and regularly reviewed
- Have a multi-disciplinary approach
- Are readily available to all staff, including locum staff and midwifery staff
- Are adhered to in practice

Recommendation 7.3

Mandate and support a full programme of clinically-led audit with a nominated consultant lead to measure performance and outcomes against guidelines.

The Maternity Department process to support and mandate any clinical audits is authorised by the Obstetric Guideline and Audit group. This is to ensure that appropriate audits are conducted in line with the HB Quality and Improvement plan.

Auditable Standards are formatted for all guidelines. Currently audits are performed on an informal basis but require a more formal structure to ensure that these occur regularly and that any learning is circulated across the HB

WHAT DID WE FIND?

Recommendation 7.5

Agree a Cardiotocography training programme that includes a competency assessment, which is delivered to all staff involved in the care of pregnant women, both in the antenatal period and intrapartum.

HDUHB has implemented the All Wales Intrapartum Fetal Surveillance Standards which does not include an All Wales Competency Assessment Tool.

There is no All Wales competency assessment tool in the All Wales Standards and an assessment tool is in the process of review at an All Wales Task and Finish Group

To develop a more robust process for capturing compliance of attendance at the weekly CTG case reviews.

Recommendation 7.6

Obstetrician & Gynaecologist Consultant staff must deliver:

A standard induction programme for all new junior medical staff

A standard induction programme for all locum doctors

WHAT DID WE FIND?

Recommendation 7.9

Develop a trigger list for situations which require consultant presence on the labour ward which much be:

Agreed by all consultants in obstetrics, paediatrics and anaesthetics and senior midwives.

Audited and reported on the maternity dashboard

Recommendation 7.11

Ensure mandatory attendance at key meetings for all appropriate staff.

Attendance must be recorded and included in staff appraisals.

Ensure that meetings are scheduled or elective clinical activity modified to allow attendance at: Perinatal Mortality meetings; Governance meetings; Audit meetings

WHAT DID WE FIND?

Recommendation:7.25

Appoint a Consultant and Midwifery Lead for Clinical Audit/Quality Improvement with sufficient time and support to fulfil the role to ensure

That clinical audits are multidisciplinary

That there is a clinically validated system for data collection

Sharing of the outcomes of clinical audits and the performance against national standards

That the lead encourages all medical staff to complete an audit/quality improvement project each year to form part of their annual appraisal dataset

Recommendation: 7.29

Closely monitor bank hours undertaken by midwives employed by the Health Board to ensure:

The total number of hours is not excessive

The HB complies with the European Working Time Directive

These do not compromise safety

WHAT DID WE FIND?

Recommendation: 7.32

Ensure Obstetric Consultant cover is achieved in all clinical areas when required by:

Reviewing the clinical timetables to ensure that 12 hour cover per day on labour ward is achieved

Considering working in teams to ensure a senior member of the team is available in clinics and provide cross cover for each other

Considering the creative use of consultant time in regular hours and out of hours to limit the use of locums

Undertake a series of visits to units where extended consultant labour ward presence has been implemented

Recommendation: 7.35

Undertake a training needs assessment for all staff to identify skills gaps and target additional training

RECOMMENDATION: 7.35

Clinical supervision and consultant oversight of practical procedures must be in place of all staff including specialist midwives and doctors

WHAT DID WE FIND?

Recommendation: 7.44

Support training in clinical leadership

The HB must allow adequate time and support for clinical leadership to function

Recommendation: 7.45

Provide mentorship and support to the Clinical Director

Define the responsibilities of this role

Ensure there are measurable performance indicators

Ensure informed HR advice to consistently manage colleagues' absence and deployment of staff to cover the needs of the service

Consider buddying with a Clinical Director from a neighbouring HB.

WHAT DID WE FIND?

RECOMMENDATION: 7.46

Appoint clinical leads in a structure that supports the service with defined role descriptions and job descriptions and objectives to include an individual response for each of the following:

- Governance and clinical quality to include guideline updating
- Data quality and audit
- Medical staff education and training
- Multi-disciplinary training
- Risk management, incident review, complaints management

Recommendation: 7.47

Develop and strengthen the role and capacity of the Maternity Services Liaison Committee (MSLC) to act as a hub for service user views and involvement of women and families to improve maternity care:

- Appoint a Lay Chair as a matter of priority and increase lay membership numbers with appropriate support and resources
- Enhance the MSLC monitoring role in order to assess whether patterns of concerns are found and to ask for regular feedback on action taken
- Support lay members to engage with women using services in the Foetal Medicine Unit and Royal Glamorgan Hospital and at Prince Charles Hospital to assess satisfaction and to identify issues relating to choices

WHAT DID WE FIND?

Recommendation: 7.57

Continue with efforts to recruit and retain permanent staff

RECOMMENDATION7.67

Develop a strategic vision for the maternity service and use the current opportunity of change to create a modern service that is responsive to the women and their families and the staff who provide care

NEXT STEPS

- Review the areas which require further assessment and develop programmes of support to achieve completion
- Revisit areas RAG rated Green to provide assurance of imbedded change
- Stop, Start or Continue
- Celebrate the achievements of the team
- Looking ahead – CTM Neonatal Deep Dive 2022 and the Ockenden Report 2022
- Create capacity and capability to future proof the service

Recommendation

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