Meeting Date	**22 November 2022**	**Agenda Item**	**4.7**
Report Title	**Outcome of the external review of Swansea Bay University Health Board Maternity Services Governance Process conducted by the Wales Maternity & Neonatal Network**		
Report Author	Susan Jose, Head of Midwifery		
Report Sponsor	Lesley Jenkins, Nurse Director, NPTSSG and Gareth Howells, Executive Nurse Director		
Presented by	Gareth Howells, Executive Nurse Director		
Freedom of Information	Open		
Purpose of the Report	To provide the Quality & Safety Committee with the key outcomes from the external review of governance processes in maternity services. To note that an action plan is being developed to take forward the recommendations.		
Key Issues	• The review panel report provides assurance on the robustness of the governance arrangements within maternity services • Certain areas were commended as best practice • Recommendations were made for improvements which the service has developed into a draft action plan to be ratified via Divisional and Service Group Quality & Safety Groups. It will be completed by and approved by end of November 2022.		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐
Recommendations	Members are asked to: • **NOTE** the contents of the external review • **NOTE** the development of the action plan based on the findings of the review, which will be completed by the end of November by the Head of Midwifery and Maternity • **NOTE** that the HB Quality & Safety Group will oversee the action plan implementation and the Executive Nurse Director will regularly review it. • **NOTE** the service group biannual maternity and neonatal performance group will increase in		

	frequency to quarterly and will be chaired by the Executive Director of Nursing • **NOTE** the extension of the maternity performance dashboard to include patient experience information to be completed by December 2022

Outcome of the external review of Swansea Bay University Health Board Maternity Services Governance Process conducted by the Wales Maternity & Neonatal Network

1. INTRODUCTION

This report will present the key findings of the commissioned external review of Swansea Bay University Health Board Maternity Services Governance Process. The external review conducted by the Wales Maternity & Neonatal Network took place on the 24th and 25th August 2022.

2. BACKGROUND

On the 22nd February 2022 a letter was received into the Health Board expressing concern that the maternity service failed to identify learning related to maternity care provided to a woman and her baby. In response to the letter, the Chief Executive Office, Executive Nurse Director and Executive Medical Director required external assurance of the governance processes within the maternity service.

Within the previous three years, Healthcare Inspectorate Wales completed unscheduled regulatory inspections in Singleton Obstetric Services 24th – 26th June 2019 and Neath Port Talbot Freestanding Birth Centre 22nd and 23rd October 2019, who found no immediate assurance requirements for the governance of the maternity service.

The health board considered the Wales Maternity and Neonatal Network a suitable external organisation to provide a secondary external assurance review specifically related to the maternity governance processes of the health board. The WMNN developed the Wales National Assurance Document for health board self-assessment in response to the Report into maternity services at Cwm Taf Health Board (2019) and The Ockenden report (2020).

The Terms of Reference set out the purpose and scope of the review as follows:

PURPOSE

The purpose of this review is to report on the maternity service governance systems for the health board assurance of robust investigation processes and importantly, outcome learning is identified and shared. If any issues are raised, it will also afford the Health Board the opportunity to rectify and ensure services are of a high standard.

SCOPE AND OBJECTIVES

- *Review relevant Health Board governance process and systems that support the delivery of safe maternity services. The scope will include the reporting structure for concerns, management and use of datix incident reporting, learning from internal and external reports and reviews.*
- *Review of the governance structures and reporting systems from clinical forums through the maternity Quality and safety Group to the Executive Board.*

- *Review the data collection systems within the health board*
- *To review the workforce specialist posts/roles in place*
- *Review of the training and education programme ensuring the MDT have the opportunity to access quality training needed to undertake their role.*
- *Evidence that the service is gathering and acting upon the experience of care provided to women and their babies by the Health Board's maternity services, based on local patient feedback and experience data*
- *Evidence that the service is gathering and acting upon feedback from the staff across the MDT within the Health Board maternity service.*
- *Advise on future improvements and maintenance of quality, patient safety and assurance mechanisms*

The scope of the review will not include;

- *the review of records or the delivery of clinical care systems*
- *a review of the performance measures*
- *1:1 staff discussions*
- *1:1 discussions with service users*

The review was conducted over a two-day period, 24th and 25th August 2022. The review team consisted of the WMNN Clinical Lead Obstetrician, Lead Midwife and Network Manager. The WMNN Review team requested a file of evidence be prepared in advance of the review describing the maternity service governance processes and the application of the process to safe service, service user involvement and service development. The maternity team prepared a comprehensive agenda and evidence stack to demonstrate the functioning of the governance process with examples of initiatives in place.

On completion of the WMNN review, the prepared report was submitted to the Executive Nurse Director on 17th October 2022 setting out the findings of the review (Appendix 1).

The framework for the review included four key terms of reference

- Risk Management and Safety
- Patient/Service User Involvement
- Data, Clinical Effectiveness, Clinical Audit and Quality Improvement
- Workforce and training

The review panel concluded that the Health Board delivers a culture of patient safety, and prioritises opportunities for improvement, through reflecting on data and lessons learned through adverse events. The panel were satisfied with the multiple examples of multi-disciplinary team working and the perinatal approach to service delivery.

The panel was assured that the Health Board is committed to ensuring that the voice of the service user is heard.

The panel highlighted exemplar initiatives and commended the Health Board on the development of a Hypoxic Ischaemic Encephalopathy (HIE) review tool incorporating parents' voices.

The panel were unable to meet with some key members of the leadership team during their review due to sickness absence. They were able to meet with a number of staff members who appeared at ease and were happy and encouraged to speak openly with the panel in the presence of senior management. Staff indicated to the review panel they were *"accustomed to seeing senior managers on the wards regularly who were visible and accessible*".

The review panel provided recommendations for further development and improvement in the governance process and systems within the four key terms of reference.

1. Risk Management and Safety

The maternity team advised the review panel of the reduction in the numbers of Datix incident reports during the changeover of the national reporting system. The review panel recommended the number of incident reports submitted each month would benefit from presentation in a run chart for early identification of reporting trends.

Midwives informed the panel that midwives completed the vast majority of Datix incident reports for maternity care while neonatologists reported for neonates.

The review panel considered the evidence provided from a "learning from events" (LFE) meeting on "Teams" to be good practice and recommended that dissemination of learning from all Root Cause Analysis (RCA) reviews be cascaded in the same manner, with a register of attendees maintained to further evidence shared learning. The review panel did recognise this might have significant resource implications.

2. Patient/Service user involvement

The review panel commended the development of the Maternity Voices Partnership (MVP), within the Family Engagement Framework. The MVP include the "15 steps" toolkit within their annual plan. The review panel recommends that the Health Board identifies a source of funding (for example charitable funds), to enable the suggestions and recommendations identified as part of the "15 steps" exercise to be implemented.

The panel recommends that the Health Board seriously consider the appointment of a Patient Experience Midwife, as included in year two of the three-year plan of the framework, for the benefits the role would bring to the service.

3. Data, Clinical Effectiveness, Clinical Audit and Quality Improvement (QI)

The review panel reviewed the maternity dashboard maintained by the Health Board. While recognising the absence of national service specifications for maternity and

neonatal services, the panel advised that the Health Board needs to demonstrate how local maternity data informs service improvement.

The review panel recommends the expansion of the current clinical maternity dashboard to include quality information for patient experience, complaints, concerns and compliments. This work is already underway with a plan to finalise by December 2022.

The panel were provided with examples of the monthly Quality Assurance and spot checks from the clinical areas, although the evidence was not included and this will be included in future.

4. Workforce & training

The panel were informed of the challenge of maintaining training compliance during a period of service pressure and critical midwifery staffing levels. The panel did not have the opportunity to meet with many staff to discuss this issue. The panel recommends that the service continue to focus on delivering education and learning updates in both formal and informal settings to maintain compliance.

A recommendation from the panel was the relocation of senior midwifery managers office accommodation adjacent to the clinical areas for further increase in the visibility and support they provide.

The panel noted that the clinical midwifery managers spoken with during the review have not received any formal training in management. This will be included in the action plan.

The maternity team will receive the report into the Quality & Safety Group to agree a multi-disciplinary action plan for the recommendations noted in the report. The agreed action plan will be submitted to NPT/SSG Service Group Quality & Safety Group for ratification.

The MNNN have requested a formal debrief with the Health Board to learn from their experience of a first request to be involved in an external Health Board review.

3. GOVERNANCE AND RISK ISSUES

The review panel concluded that the Health Board delivers a culture of patient safety, and prioritises opportunities for improvement, through reflecting on data and lessons learned through adverse events. The panel were satisfied with the multiple examples on multi-disciplinary team working and the perinatal approach to service delivery.

The panel were assured the Health Board is committed to ensuring that the voice of the service user is heard.

The panel highlighted exemplar initiatives and commended the Health Board on the development of a Hypoxic Ischaemic Encephalopathy (HIE) review tool incorporating parents' voices.

The maternity service will need to prioritise the further development of the maternity dashboard to ensure evidence is available future development is driven by both qualitative and quantitative data. Lessons from national reports of failing maternity services can be used to formulate the inclusion criteria in the development of the dashboard. An initial meeting has been held with business intelligence partners with further follow up planned. This will support the service ability to provide visual assurance to the Board and support the maternity and neonatal performance Board currently in development.

Maternity specific training compliance to be included in a dashboard for assurance and identification of fall off in compliance for immediate action planning. Work to include how maternity service measure and report training compliance in electronic format (including ESR).

The family engagement framework to be re-invigorated to continue the work already completed. Year two of the framework includes the development of a patient experience midwife to strengthen the partnership working between the MVP and governance team. This will be presented to the NPTSSG Quality, Safety & Risk meeting.

4. FINANCIAL IMPLICATIONS

Clarity about financial implications will arise from the development of the action plan.

The maternity service will explore the financial sources available to fund changes from the “15 steps” exercise.

5. RECOMMENDATION

Members are asked to:

- **NOTE** the contents of the external review
- **NOTE** the development of the action plan based on the findings of the review, which will be completed by the end of November by the Head of Midwifery and Maternity
- **NOTE** that the HB Quality & Safety Group will oversee the action plan implementation and the Executive Nurse Director will regularly review it.
- **NOTE** the service group biannual maternity and neonatal performance group will increase in frequency to quarterly and will be chaired by the Executive Director of Nursing
- **NOTE** the extension of the maternity performance dashboard to include patient experience information to be completed by December 2022

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
Not applicable – for noting only at this stage		
Financial Implications		
Not applicable – for noting only at this stage		
Legal Implications (including equality and diversity assessment)		
Not applicable		
Staffing Implications		
Not applicable		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
Not applicable		
Report History	Not applicable	
Appendices		
Appendix 1	External Review Final Report	