Welsh Government
Maternity Strategy

Report from Quality and Safety Sub-Group

June 2013
Terms of reference of the Quality and Safety Sub Group

1 To review, collate and evaluate existing guidelines, surveys, audits and other quality and safety reporting mechanisms relating to maternity and perinatal services.

2 To assess the robustness of existing Wales wide quality and safety mechanisms in maternity and perinatal services, identify overlaps, gaps and recommend structural improvements.

3 To identify ways to promote the integration of quality and safety into maternity and perinatal service provision, and recommend actions to promote such a culture in NHS Wales.

Review of existing systems for Quality and Safety Reporting in maternity and neonatal services

4 There are a number of important audit and reporting systems currently in use. These are listed in Appendix 1.

5 Gap analysis: Although publicly available, these systems (such as BADGERnet, AWPS, Welsh Risk Pool etc) are not systematically used by services across Wales to audit, evaluate or benchmark services to improve quality and safety.

6 Action is required by Local Health Boards (LHBs) and Welsh Government (WG) to ensure that the professional groups delivering maternity and neonatal services across Wales are effectively networked with each other and with existing quality and safety systems.

Quality standards and resources identified

7 A library of links to quality resources for maternity has been established within the Welsh Government.

8 Gap analysis: Quality resources for service improvement are not fully accessible to all clinicians via the NHS intranet due to a combination of hardware and software issues (including bandwidth, access to intranet and internet).

9 Action is required by LHBs to ensure all staff can access quality improvement resources and sources of information at their workplace.
Evidence that existing systems are reporting effectively and consistently to achieve quality, safety and learning

10 LHB incident reporting via DATIX (reported to National Reporting and Learning System) and the WG serious incident reporting system ‘Putting Things Right’ are in operation. There are wide variations in reporting rates which may indicate inconsistent application of reporting criteria across LHBs. There is no clear route of feedback to clinicians about high cost compensation cases following birth injury.

11 The Royal College of Obstetricians and Gynaecologists (RCOG) Clinical Indicators project has been running since 2011 in England exploring the considerable variation in obstetric care delivered at different NHS units, variation in case mix and outcomes. They are developing and validating a suite of outcome indicators. Links have been established with WG, Public Health Wales (PHW) and NHS Wales Informatics Service (NWIS) to explore the scope to apply these finding in Wales.

12 Gap analysis: These reporting systems are not currently being harnessed to provide systematic timely feedback to clinicians on errors and incidents from all significant routes.

13 Action is required by LHBs and WG to ensure that the professional groups delivering maternity and neonatal services across Wales undertake Wales-wide, systematic and planned interprofessional activity to review quality and safety of services, use common valid outcome indicators to share learning and skills and benchmark themselves against comparable services.

Quality and safety projects under way in Wales

14 Cardiotocography (CTG) training: This working group has been working on standards, training and accreditation for CTG interpretation which is recurrently identified as a risk factor in high cost claims. The findings from this work will be disseminated through LHBs and professional structures.

15 Wales Initiative for Stillbirth Reduction (WISR): This working group has developed a work plan to address a range of issues including a protocol for reduced fetal movements, training for professionals in post mortem consent and is exploring research possibilities. Messages are being disseminated through the 1000 lives+ maternity mini collaborative structure.

16 Gap analysis: There are numerous professional fora and project based initiatives for professionals involved in maternity and prenatal care. These have huge potential to share practice and disseminate learning to improve quality and safety of care in organisations, but need to be brought together into a coherent professional network to avoid gaps and duplication.
There are multiple sources of learning and information on quality and safety including audit and significant event reporting systems but these are not all in routine, consistent use, to achieve timely, effective learning on a Wales wide basis.

There is insufficient coordination and use of routinely collected data (e.g. local dashboards, NWIS, All Wales Perinatal Survey (AWPS) and BADGERNET) to derive meaningful outcomes, evaluate and benchmark performance and drive improvement.

**Recommendations from the Quality and Safety Working Group:**

An All Wales Maternity / Perinatal Clinical Network should be developed, to allow clinical discussion, benchmarking, use and coordination of routinely collected data, coordination and dissemination of learning, and quality improvement programmes. The most appropriate model for such a network could be the 1000 Lives+ or the Neonatal Network, and would need further exploration in conjunction with professional groups.

**Recommendation 1:** LHBs should develop and resource a clinical professional forum to support the functions of a Maternity /Perinatal clinical network with clinical leadership and regular meetings. (See appendix 2 for maternity network proposal and models)

An annual feedback cycle of Maternity quality and safety reporting from LHBs should feed back to clinical service to ensure learning, and inform the WG on achievement of quality standards via an all- Wales national clinical audit programme. This should be informed by experience from elsewhere, especially the successful model being used in Scotland.

**Recommendation 2:** A Maternity /Perinatal clinical network should develop a work programme which corresponds to ongoing LHB quality and safety obligations including a nationally agreed audit and confidential enquiry programme. This would feed into the Wales National Audit Advisory Committee. A high priority could be to explore the variation of Caesarean Section rates throughout Wales.

Wales should promote the coordination of the different maternity dashboards currently in use in LHBs throughout Wales to enable LHBs to support clinical review and audit through use of a common standardised minimum data set for easy comparison of maternal morbidity.

**Recommendation 3:** A Maternity /Perinatal clinical network should develop an agreed, common standardised set of outcome measures supported by coordinated data collection from dashboards throughout Wales.
22 Stillbirth reporting via AWPS should be coordinated with MBRRACE, BADGERnet data and the 1000 lives National Stillbirth working group project to assist the development of better reporting of all stillbirths, as well as work with the UK CORP to validate and benchmark infant deaths and maternal deaths.

**Recommendation 4:** A Maternity /Perinatal clinical network should coordinate MBRRACE, AWPS and BADGERnet and other reporting systems to inform clinicians throughout Wales of untoward outcomes in a timely manner.

23 All Wales learning systems should be developed, as part of a clinical network, to allow dissemination of learning from a range of events, audit reporting etc, including cardiotocograph Interpretation training, advice regarding reduced fetal movements and any other areas identified though local quality monitoring of services.

**Recommendation 5:** A Maternity /Perinatal clinical network should develop a coordinated NHS intranet resource to support common LHB learning needs with a programme of learning events including audit presentations, significant event review and peer discussion.

24 Research and development are essential components of continuous improvement and ensuring high quality services and professionals. A professional network would be an important source of advice on future research priorities.

**Recommendation 6:** A Maternity /Perinatal clinical network should advise LHBs and WG on a research and development agenda for NHS Wales.

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**Appendix 1:**

**Existing systems for Quality and Safety reporting in maternity and neonatal services**

1. **All Wales Perinatal Survey (AWPS)** – reports published annually on all stillbirths and infant deaths.  
   [http://medicine.cf.ac.uk/awps/](http://medicine.cf.ac.uk/awps/)

2. **BADGERNET** – reports clinical audit data for the Neonatal network – all units now participating, reports to become available ion 2013.  
3. Local Maternity Dashboards – Used by every LHB, they show considerable local variation. There is huge scope for a Wales wide coordination which is being addressed as part of the Maternity Strategy Informatics subgroup, NWIS and PHW.

4. RCOG Clinical Indicators project – this has been running since 2011 in England exploring the considerable variation in obstetric care delivered at different NHS units, variation in case mix and outcomes. They are developing and validation a suite of outcome indicators. Links have been established with WG, PHW and NWIS.

5. 1000 lives + maternity mini collaborative – engages clinicians, holds learning events and disseminates research and models of good practice. Now hosting the Wales Initiative for Stillbirth Reduction (WISR)
www.1000livesplus.wales.nhs.uk/maternity

6. Healthcare Quality improvement Partnership (HQIP) was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales. It is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices (formerly the Long-term Conditions Alliance). HQIP is a charity and company limited by guarantee. It coordinates and manages the nationally commissioned Clinical Audit Programme (NCAPOP), National Joint Registry (NJR) and CORP (Confidential Enquiries).
http://www.hqip.org.uk/

7. The Maternal and Infant Clinical Outcome Review Programme (CORP) managed by HQIP, is now delivered by MBRRACE (successor to CEMACE) using a secure electronic portal for reporting, all maternal deaths, stillbirths and infant deaths, with reporting and confidential enquiry function in cooperation with AWPS.

8. Putting Things Right
(link to revised guidance issued April 2012 – advise don’t print- 230 pages) – Welsh Government Patient Safety Serious Incident reporting procedure – serious patient safety incidents according to set criteria including stillbirths, infant and maternal deaths where there is also considered to be a link to midwifery or obstetric practice.

9. Welsh Health Legal Services and Welsh Risk Pool
litigated cases – reports only go to LHB risk managers and at present provide no regular feedback direct to clinicians.
10. **Local Supervising Authority for Midwives**  
   [http://www.hiw.org.uk/page.cfm?orgId=477&pid=13891](http://www.hiw.org.uk/page.cfm?orgId=477&pid=13891) – The LSA reviews care relating to stillbirths, maternal deaths and any cases of professional concern where there is considered to be a link to midwifery practice.

11. **Healthcare Inspectorate Wales (HIW)**  
   NMC guidelines for statutory supervision of midwives (includes criteria for reporting to LSA) – [http://www.hiw.org.uk/page.cfm?orgid=477&pid=14742](http://www.hiw.org.uk/page.cfm?orgid=477&pid=14742)

12. **Public Services Ombudsman for Wales**  
   [http://www.ombudsman-wales.org.uk/](http://www.ombudsman-wales.org.uk/) Independent of government, with legal powers to investigate complaints about public services in Wales, and complaints that members of local government bodies have broken their authority’s code of conduct. Reports published on a regular basis.

13. **Wales Audit Office**  

14. **National Learning and Reporting System (NRLS)**  
   [http://www.nrls.npsa.nhs.uk](http://www.nrls.npsa.nhs.uk) – routine reporting from the NHS (DATIX) of all patient safety incidents – also publishes rapid response reports.

15. **Medicines and Healthcare Products Regulatory Agency (MHRA)** routine reporting from the NHS (DATIX) of all patient safety incidents involving medicines, products or appliances.  

16. **Central Alerting System (CAS)** – this is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. CAS was established in 2008, replacing the previous Public Health Link (PHL) and Safety Alert Broadcast System (SABS). Issued alerts are available on the CAS website and include safety alerts, CMO messages, drug alerts, Dear Doctor letters and Medical Device Alerts issued on behalf of the Medicines and Healthcare products Regulatory Agency, the National Patient Safety Agency, and the Department of Health.  
   [https://www.cas.dh.gov.uk/Home.aspx](https://www.cas.dh.gov.uk/Home.aspx)
17. **Coroners Rule 43 reports** – Under Rule 43 Coroners have a wider remit to make reports to prevent future deaths. A person who receives a report must send the coroner a written response; coroners must provide interested persons to the inquest and the Lord Chancellor with a copy of the report and the response; coroners may send a copy of the report and the response to any other person or organisation with an interest; the Lord Chancellor may publish the report and response, or a summary of them; and the Lord Chancellor may send a copy of the report and the response to any other person or organisation with an interest. [www.justice.gov.uk/...coroners/coroners-reports-future-deaths.pdf](http://www.justice.gov.uk/...coroners/coroners-reports-future-deaths.pdf) (This is not a complete link)

18. Following changes to the NPSA, the NRLS function is now with Imperial College Healthcare Foundation NHS Trust which analyses data submitted from Wales. The rest of the NPSA patient safety function has moved to the NHS CB, and work is underway to develop an agreement regarding which services will be delivered by the DSU in Wales.

Appendix 2:

Proposal for a Maternity Clinical Network for Wales – February 2013

**Introduction**

1 Maternity services in Wales have changed over the past 20 years with some closure of small units and the further development of midwifery-led units, whilst individual hospitals increasingly refer high-risk women and babies to local, larger units for delivery. We have also seen the development of specialist fetal and maternal medicine services with significant changes to neonatal services. Unfortunately this change has not been coordinated or planned across the service in Wales. This has often created challenges for those providing care and in many cases unacceptable emergency referral rates to units in England, particularly for neonatal services.

2 The report of the Department of Health expert group into the provision of neonatal services in 2003 suggested the need for managed clinical neonatal networks. In 2007 the *Maternity Matters* report stated that women and families should be offered a choice of antenatal care within maternity, neonatal and perinatal mental health networks. Also in 2007, the RCOG in conjunction with the RCM and the RCA and RCPCH published *Safer Childbirth*. This document suggested maternity networks as a solution to the problems of service provision where smaller units were unable to continue to provide a full complement of maternity services. The call for maternity services within clinical networks was further advanced by the RCOG in 2011 in its document ‘Tomorrow’s Specialist’.

3 Welsh Risk Pool data suggests that litigation costs for maternity claims are a significant resource implication for the service. Best estimates suggest this cost is unfavourable when
compared to the English service which itself paid out in excess of £3 billion between 2000-2010. It is essential that effective governance measures are introduced to manage this risk. A recent pilot of a cardiotocograph (CTG) assessment tool in Wales has demonstrated the clear need for effective CTG training for all professionals involved in maternity care across Wales. This example of an all-Wales approach highlights the need for an effective organisation to deliver training and risk reduction on a universal basis in Wales. It would be expected that a maternity network would deliver the required governance structures in Wales resulting in reduced litigation and burden for the Welsh Risk Pool.

Why do we need a Maternity Network in Wales?

4 There is a clear need to build upon the Maternity Strategy for Wales and the work currently undertaken by the All Wales Maternity Service Implementation Group (AWMSIG). This work will require a mechanism for on-going service implementation once the AWMSIG has completed its function, so that its excellent work is not lost.

5 Any planned reconfiguration of maternity care in Wales will need to be planned across a number of units and health board boundaries. Change to the function of current units will have significant impacts on the activity within neighbouring units. Any such change will need to be phased, coordinated and highly-planned. This can only be done with the support of a maternity network. In the absence of a network there is a significant risk that newly created services will lack the coherent approach required to limit the undoubted risk to mothers and babies associated with the planned large scale reconfiguration of services.

6 A high quality, collaborative, maternity service for Wales needs a commissioned, managed maternity network to ensure the families of Wales receive the best maternity services possible, regardless of location and in all birth-settings, including home delivery.

7 Health Boards would see a major benefit from an investment in a maternity network. It would help them discharge their obligations to provide safe, sustainable services for their population, offering more efficient use of resources, less duplication, quality assured, safer services with less litigation, a higher quality service that attracts the best trainees to Wales, and greater patient satisfaction and outcomes.

8 A Neonatal Managed Clinical Network for Wales was established in 2009 in order to implement the required neonatal transfer system and to deliver the Neonatal Care for Wales as defined by clinical standards. There is now a desire within the Maternity Service to reproduce a similar network for maternity services to pick up the work of the AWMSIG. The desire is shared by all healthcare professionals responsible for the delivery of maternity care in Wales.

9 This document suggests a role, purpose and structure for a Welsh Maternity Network. It describes the key roles and responsibilities of the network, its board and its stakeholders.
What is a Network?

10 A managed clinical network is a linked group of health professionals from primary, secondary and tertiary care working in a coordinated manner to ensure equitable provision of high quality clinically effective services unconstrained by existing professional and health board boundaries. A maternity network will be an important force in improving care for all women and their babies throughout pregnancy and during delivery.

11 A maternity network will have robust systems and common guidelines and governance systems to ensure the delivery and monitoring of a safe, high-quality maternity service. The maternity network would include comprehensive options for delivery settings for women including home birth, midwifery-led units and consultant-led units backed up by an effective neonatal service with robust transport systems.

12 The following benefits have been attributed to Clinical Networks:

- Integrated and standardised care – promotion of excellence through protocols / guidelines, and audit.
- Cost effective use of specialised staff and equipment
- Working together to manage risk
- Education and training and shared knowledge management
- Improve clinical outcomes and quality of patient care
- They provide better support for implementation of standards.

Who would a Maternity Network represent?

13 Welsh Maternity Network will bring together the following organisations to deliver improvements in Maternity standards of care:

- Betsi Cadwaladr Health Board
- Aneurin Bevan Health Board
- Cardiff University Health Board
- Cwm Taf Health Board
- Abertawe Bro Morgannwg Health Board
- Hywel Dda Health Board
- Powys Health Board
- Welsh Ambulance Service Trust
- Welsh Health Specialist Services Commission
- Public Health Wales
- Patient group representatives.
- Welsh Government
Membership of the Welsh Maternity Network Board

14 The Network will be established on behalf of, and report to the Health Board CEOs. Membership will require representation from:
   - Obstetric Clinical leads
   - Midwifery leads
   - Directors of planning from LHBs
   - WAST
   - Primary Care
   - Anaesthetics and Critical Care
   - Neonatal Network for Wales
   - Patient groups
   - Public Health Wales
   - Allied Health Professions
   - Pharmacy services
   - NWIS
   - Research and Development (University sector)
   - LHB Training and Education

15 The Network will continue the work of the five work-streams of the AWSMIG in the first instance.

16 The Network would meet quarterly and is quorate when 50 per cent of members are present.

17 The roles of the Network are set out below in section 6. The Board will receive reports on local progress and provide a forum for quality assurance and strategic direction for maternity services in Wales.

18 Communication through means such as videoconferencing without the need for travel enhances the role of a single network.

Role of the Maternity Network:

19 The purpose of a Maternity Network in the whole of Wales includes:
   - Ensuring similarly high quality standards across the whole of Wales with similar, but not necessarily identical, guidelines and pathways.
   - Collation of information across Wales for the purposes of audit, benchmarking and improvement of outcomes.
   - Sharing lessons learned widely across Welsh maternity services.
   - Enabling all those involved in women’s health to interact more freely, learning from each other and supporting each other.
20 The Maternity Network should be responsible for quality assurance and support for:

- Supporting the implementation of a phased reconfiguration of maternity services within Wales.
- Maternity care in all settings including midwifery-led units and home births.
- Ambulance transport of pregnant women.
- Links with other services – e.g. anaesthetic services, neonatology, other paediatric specialities, specialist medical services including cardiology, sexual health services.
- Delivering the appropriate services in the right place, as close to home as feasible.

21 The Maternity Network will offer a framework for Clinical governance:

- Implementation of RCOG and RCM clinical standards
- Audit and Guidelines
- Education and Training
- Interacting with parents, carers and parent groups
- Risk management and closer working with the Welsh Risk Pool
- Research and development

22 The Maternity Network will offer a framework for improving outcomes:

- Maintaining and improving the quality standards developed by the AWMSIG
- Providing multidisciplinary professional advice on service redesign
- Developing maternity care pathways
- Data collection and collation, including overseeing the implementation and ongoing function of the local dashboards
- Benchmarking across Wales and with units in England.
- Production of an annual report to include agreed outcome and performance measures. The need to consider both morbidity and mortality reporting is acknowledged.

23 The Maternity Network will offer a framework for Strategic planning roles to facilitate discussion on best use of resources and communicate the need for development, strategy, quality and outcomes:

- Setting multidisciplinary standards for the care of all pregnant women
- Monitoring outcomes against agreed outcome measures defined by the AWMSIG and others.
- Agreeing strategy across all maternity services
- Supporting investment
- Advising service planners and advising on the designation of units within the models proposed by Health Boards.
Options for structure and role of the Maternity Network

24 **Option 1:** Convert the Neonatal Network for Wales to a Perinatal Network in order to achieve the goals set out in this paper should be considered. This would add the maternity network to the existing infrastructure offering economies of scale and a natural consonance of work. A disadvantage would be that the agenda for both Networks may be too large at the present time. However, this would be a desirable option in the future.

25 **Option 2:** Establish one Wales-wide network underpinned by closer working relationships in the three communities of North, South-West and South-East Wales. Disadvantages are a current lack of coherence and infrastructure to support service improvement.

26 **Option 3:** Convert the 1000 lives mini collaborative into a Wales wide Maternity network with revised funding, structure and Terms of Reference.

Network Infrastructure

27 The Network would meet at an agreed venue. It will require employed staff in order to operate:

- Lead Midwife
- Lead Obstetrician
- Network Manager
- Administrative Assistant

References

A Strategic Vision for Maternity Services in Wales 2011.

