NHS
England

Lessons from the National Maternity Safety Support Programme (MSSP)

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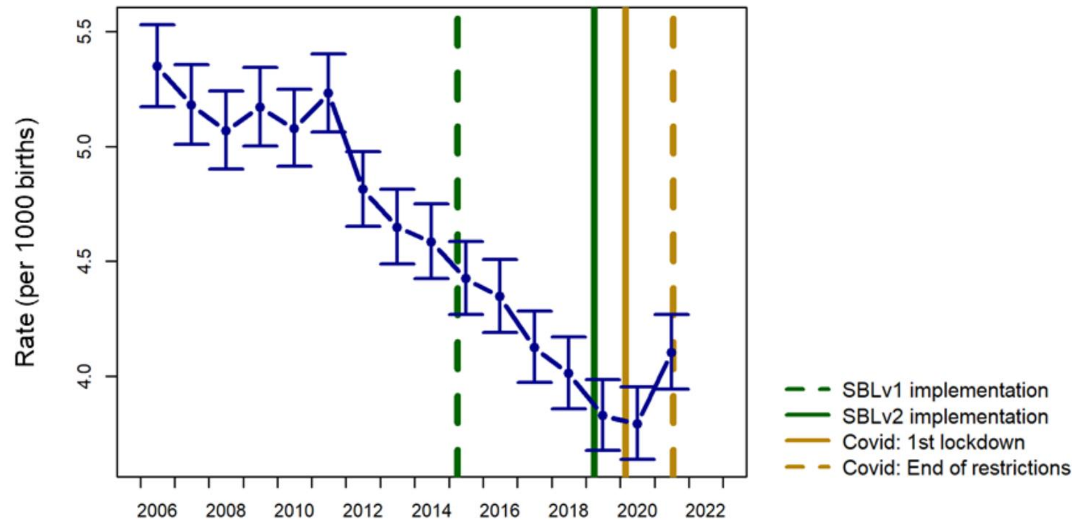
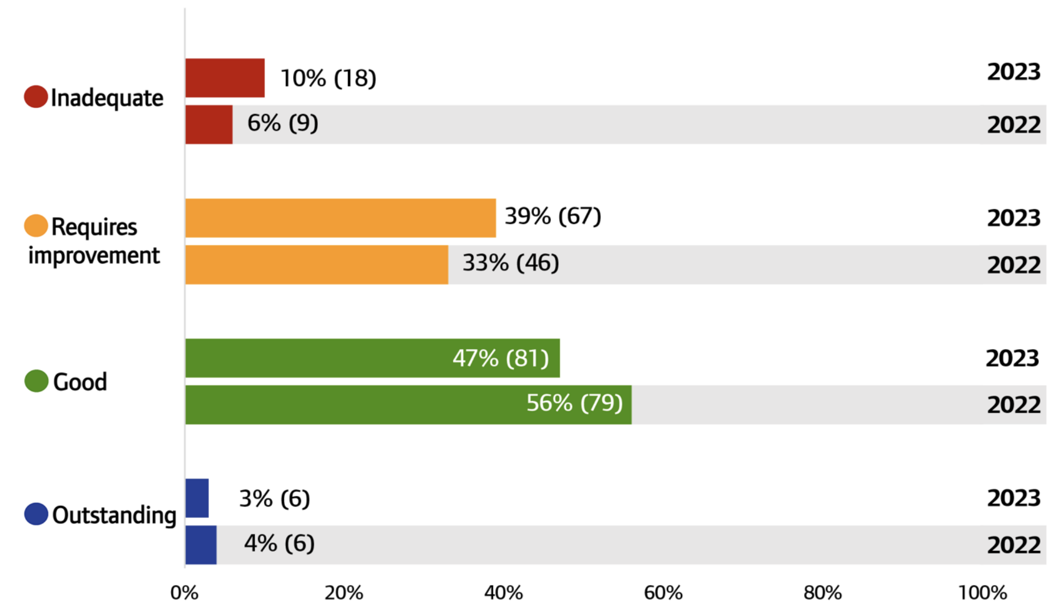
Caterina Raniolo – National Maternity
Quality Improvement Lead, NHS England
Helen McConnell- MNVP Lead, York and Scarborough

What is happening with maternity services?



Stillbirth rates in England 2005-2021

- *ONS data*



CQC Inspection programme of maternity services in England

- *State of Care 22/23*

Background and context

- Commissioned by the Secretary of State for Health and Social Care in 2017
- National Maternity and Neonatal "Halve it" Safety Ambition
- Historically based on CQC ratings
- In 2023 alignment with the NHS Oversight Framework
- System approach and reading the signals (CQC, NHS-R, Regional maternity teams, MNSI)

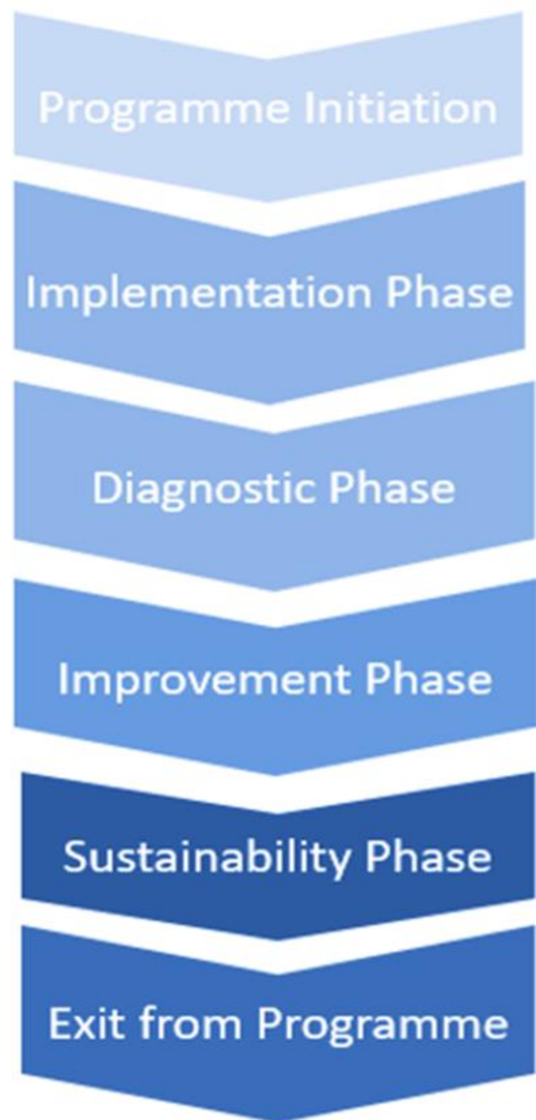
32 maternity services currently on the MSSP

9 maternity services have exited in total

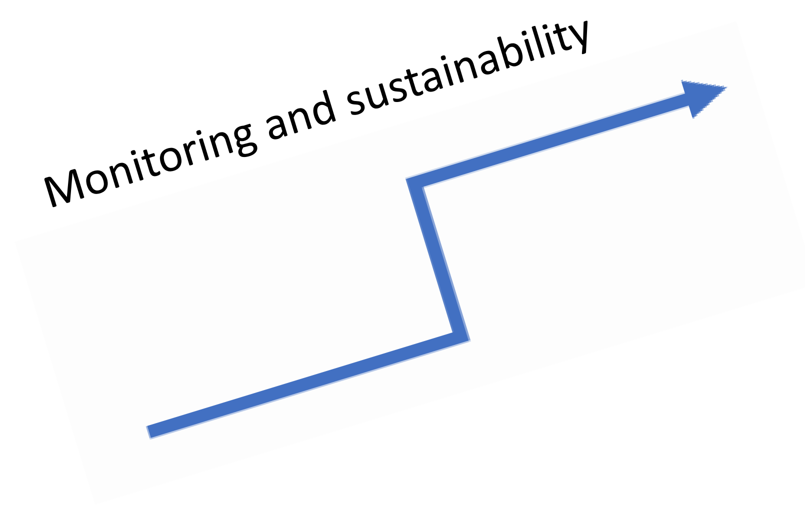
4 maternity services planning to exit

2 maternity services planning to enter

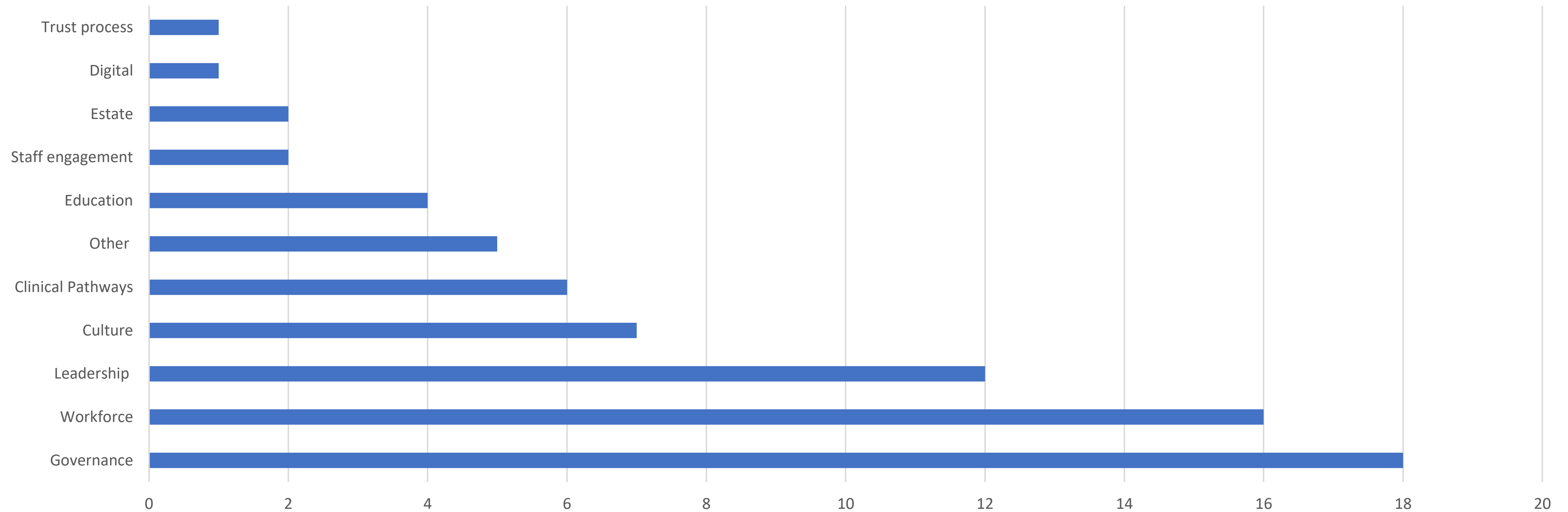
Programme phases and our approach



Appreciative enquiry



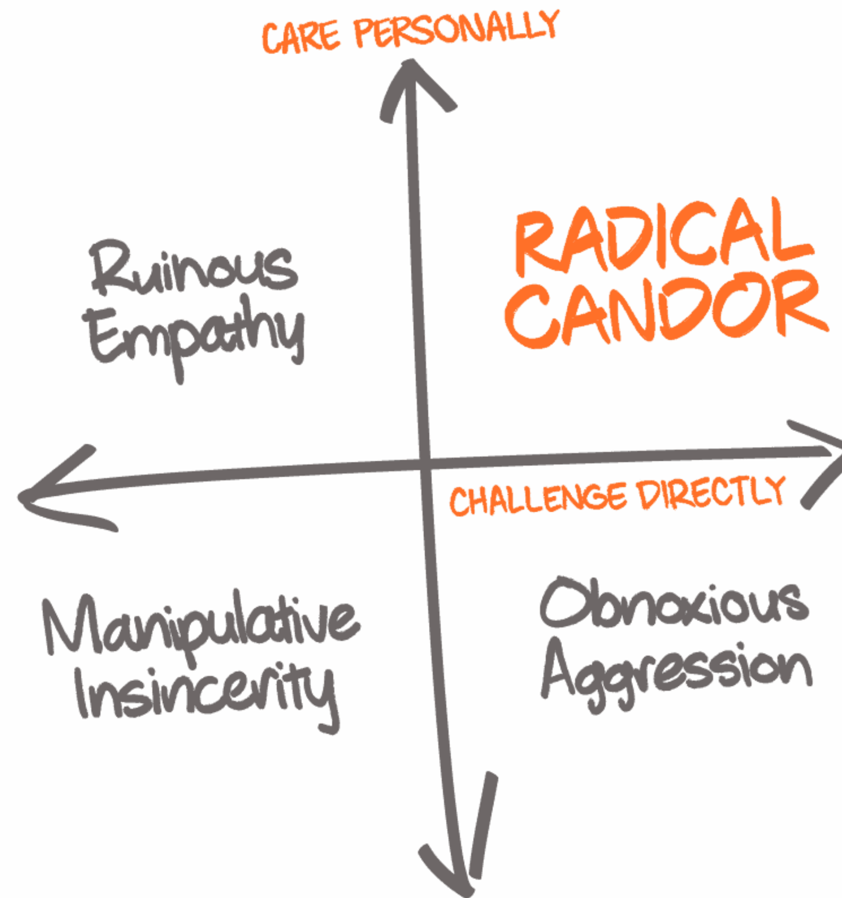
Key challenges identified in maternity services on the MSSP



Poll: What is your department's greatest challenge?

Menti.com - 64692869

Radical Candour – "being a critical friend"



Kim Scott, *Radical Candor: How to get what you want by saying what you mean (2019)*

YORK & SCARBOROUGH
Maternity & Neonatal Voices
Working in partnership to improve maternity & neonatal services

The role of the Maternity and Neonatal Voices Partnership

Providing a critical friend voice to improve maternity services

Who are we?

- MDT
- Every trust has one
- Better births report 2016
- Lay person lead
- Independent from trust and ICB

What do we do?

YORK & SCARBOROUGH
Maternity & Neonatal Voices
Working in partnership to improve maternity & neonatal services

Gather service user feedback – and anonymise

Champion the diversity of patient & public voice, views and experiences

Bring common themes together and work to build on success and implement change where needed

Provide critical friend challenge…

Critical Friend

Provides:

- Honesty
- Support
- Time
- Challenge

Not:

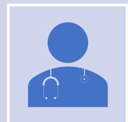
- Negative comments
- Judgement
- Disapproval
- Bias

Essential component: **trust**

When trust is there

Open and honest conversations about service user needs

Changes made that make a tangible difference to service user experience and safety



These changes build trust between service users and staff, creating a safer patient environment

When trust is missing

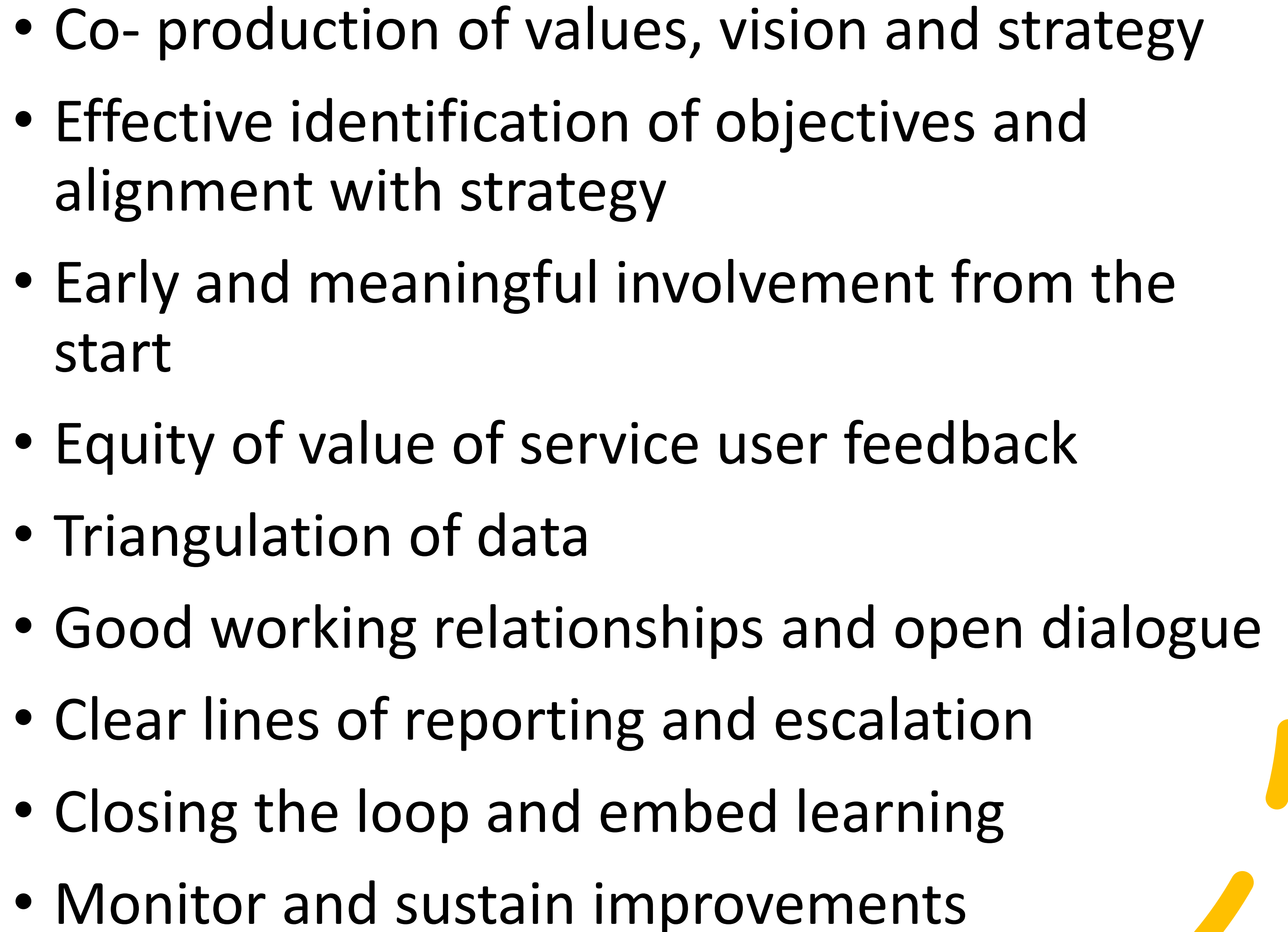
YORK & SCARBOROUGH
Maternity & Neonatal Voices
Working in partnership to improve maternity & neonatal services

Lack of trust between service users and staff, leading to lack of open conversations, in turn leading to increased risk

Poll: What is your main challenge in integrating staff, service users and other partners in improvement?

Menti.com - 64692869

Key components of effective service users integration



The Regulation and Quality Improvement Authority

RQIA REVIEW OF GOVERNANCE ARRANGEMENTS IN HSC MATERNITY SERVICES IN NORTHERN IRELAND

Leanne Morgan
Clinical Lead
RQIA

Lesley Sharkey
Director of Midwifery
NHS Tayside

FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS FROM THE INDEPENDENT REVIEW OF MATERNITY SERVICES at The Shrewsbury and Telford Hospital NHS Trust

Our Final Report

30 March 2022

Reading the signals

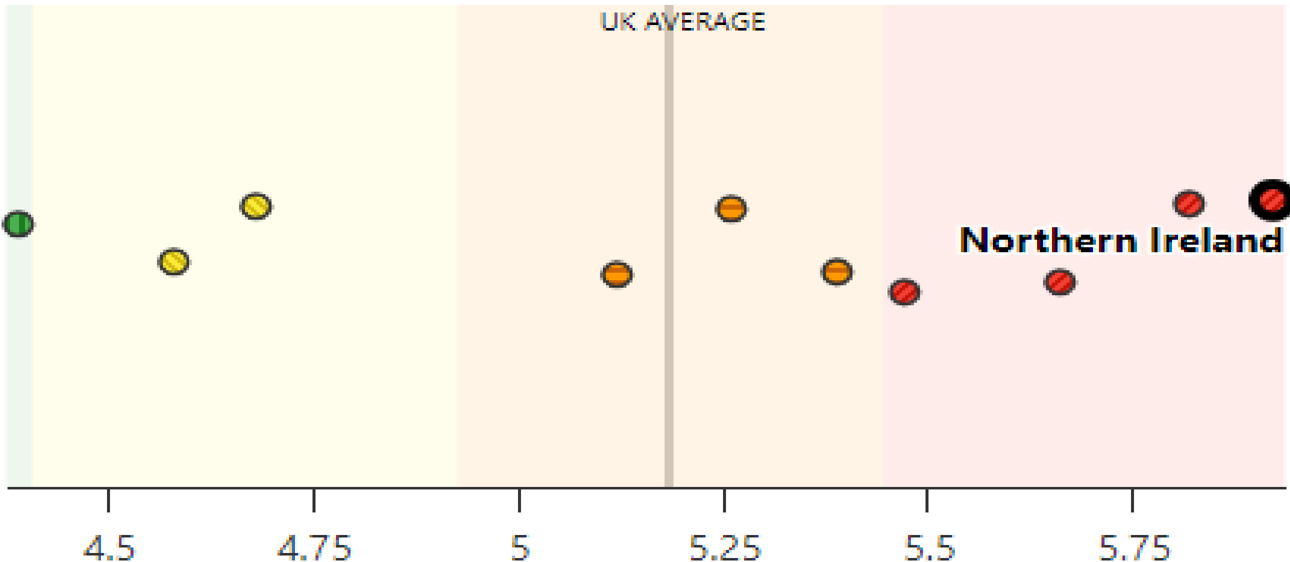
Maternity and neonatal services in East Kent – the Report of the Independent Investigation

October 2022

Dr Bill Kirkup CBE

681

MBRRACE-UK DATA



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Staff at NI hospital warn maternity services could collapse before summer'

Northern Trust maternity services fragile, vulnerable and unsustainable'

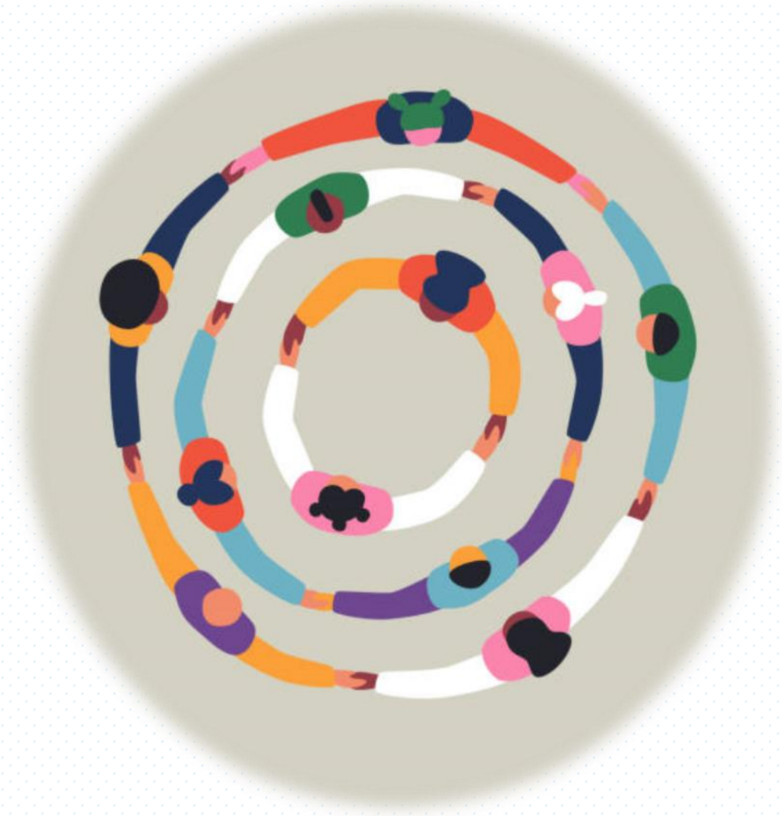
21 November 2022

Lagan Valley: South Eastern Trust pausing births at midwife-led unit

31 March 2022

Stormont stalemate: Northern reland fails to restore power-sharing

December 2022



EMPATHY

Report of the RQIA Review of Intrapartum Care

March 2010

Review of A Strategy for Maternity Care in Northern Ireland (2012-18)

March 2017

RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland

June 2022

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

HSC
Public Health
Agency

NNNI
Neonatal Network Northern Ireland

PCC
PATIENT & CLIENT COUNCIL

HSC
Health and
Social Care

Royal College
of Midwives

Royal College of
Obstetricians &
Gynaecologists

RC
GP

TERMS OF REFERENCE

To assess:	the effectiveness of overarching HSC Trust governance processes that support the safety of maternity services provided by HSC Trusts
To assess:	the effectiveness of clinical governance processes within HSC maternity services with regard to assuring safety of care
To assess:	the safety culture through seeking the views and experiences of staff on how psychological safety, learning and just culture is supported within maternity services in HSC
To seek:	the views and experiences of service users and their families in relation to maternity services in HSC
To identify:	learning and make recommendations for improvement

EXPERT REVIEW TEAM

Diane Murray	Gill Irvine	Lesley Sharkey	Leanne Morgan	Hall Graham
Former Deputy Chief Nursing Officer for Scottish Government	Consultant Obstetrician, NHS Ayrshire and Arran	Director of Midwifery, NHS Tayside	Clinical Lead, RQIA	Professional Advisor, RQIA

METHODOLOGY AND APPROACH

Development of Assurance Framework

Pre-review questionnaires; Supporting information; Data requests

Virtual focus groups with managers and clinical leaders

Engagement with service user representatives and advocacy groups

Staff Culture Survey

On site visits to each Trust were we could see units, meet face to face with managers and clinicians, front line staff in a series of meetings.

Analysis; deliberation of findings and recommendations

Focus groups with women who had used services – also with an opportunity to feed into the review via email

Maternity Safety Culture Staff Survey

Semi structured focus groups with management staff and staff in clinical leadership roles

Focus groups with front-line staff during site visits to each Trust

- Psychological safety, learning and just culture
- Need to embed principles of fairness, openness and learning
- Support for staff

Recommendation

Each HSC Trust should review their arrangements for staffing escalation and should ensure that the measures used to roster additional staff at short notice are sensitive to their wellbeing needs. In particular, HSC Trusts should engage with staff to explore suitable alternatives to ‘SOS’ WhatsApp groups.

- "I had an amazing journey with my second baby; I saw the same doctor at each appointment and was given a number to ring if I needed anything"

- "My bereavement midwife was an angel. I felt like I could tell her anything and not be judged. She let me know it was okay to have difficult and challenging feelings."

- Board level oversight and safety champions
- Safe staffing levels
- Workforce planning and management

- Systems and pathways for scheduled and unscheduled maternity care
- Pathways of support for social complexity; ethnic diversity; care outside guidance
- Holistic approach to assurance

- ❖ Vision for safety and strategic direction
- ❖ Maternity Network
- ❖ Regionally agreed safety metrics

LESSONS LEARNED

How to conduct a review/investigation with psychological safety, empathy and a focus on ‘work as done’

REVIEW PLANNING AND PREPARATION

Clarity of purpose
- Focus on learning and improvement
- Utilise all opportunities to communicate the purpose

Recruit skilled and empathetic reviewers
- Subject matter experts
- Empathy, compassion and sensitivity

Design robust methodology balanced by a sensitive approach
- Deliver on Terms of Reference
- Aim to maximise engagement
- Take steps to mitigate distress cause by investigation process

REVIEW FIELDWORK

Create psychological safety at every encounter	Encourage contribution	Enquire with curiosity	Non-judgemental approach
Trauma-informed approach	Offer choice	Respect autonomy	Validate concerns
Model empathy and compassion	Express gratitude for candid accounts	Acknowledge difficult disclosures	Ensure access to support

ANALYSIS, DELIBERATION AND REPORTING

Robust Analysis
- Triangulate data
- Consider limitations
- Utilise skills and expertise of panel

Evidence-based recommendations
- Reflect just culture principles
- Consider all relevant stakeholders
- Prioritise – urgency and key enablers
- Aim for co-ordinated, sustained improvement

Fair, measured and balanced reporting
- Mitigate unintended consequences to servicer users and staff

SPECIAL THANKS

To colleagues on Project Team and Expert Review Team:

- **Helen Hamilton** Project Manager, RQIA
- **Lheanna Kent** Project Support Officer, RQIA
- **Diane Murray** Former Deputy Chief Nursing Officer for Scottish Government
- **Gill Irvine** Consultant Obstetrician, NHS Ayrshire and Arran
- **Hall Graham** Professional Advisor, RQIA

A special thanks to the women, advocacy groups, maternity clinicians, leaders and managers who engaged with the Review Team

Thank you!

QUESTIONS?