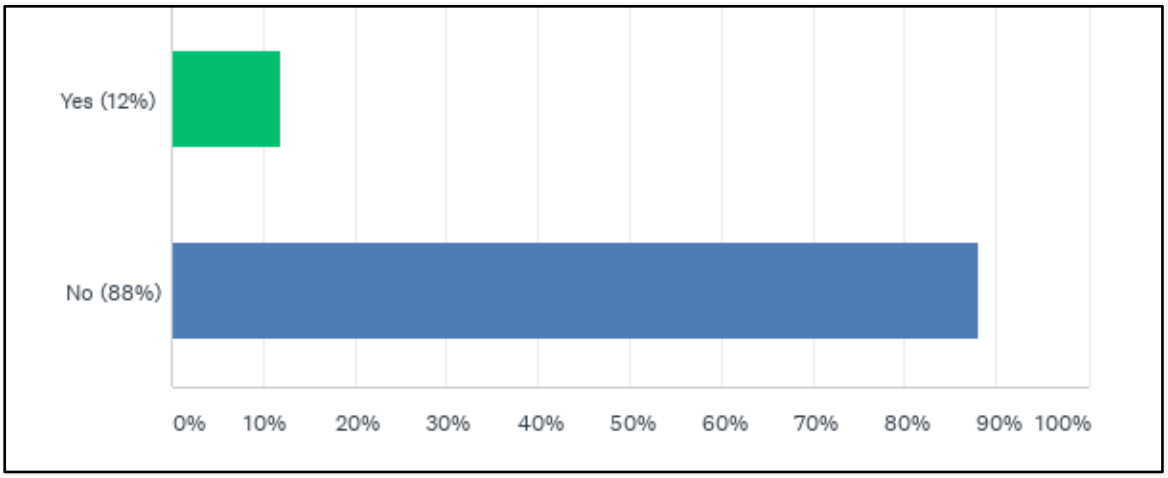
Maternity Services

Addressing a punitive culture – a pilot questionnaire to test recent initiatives

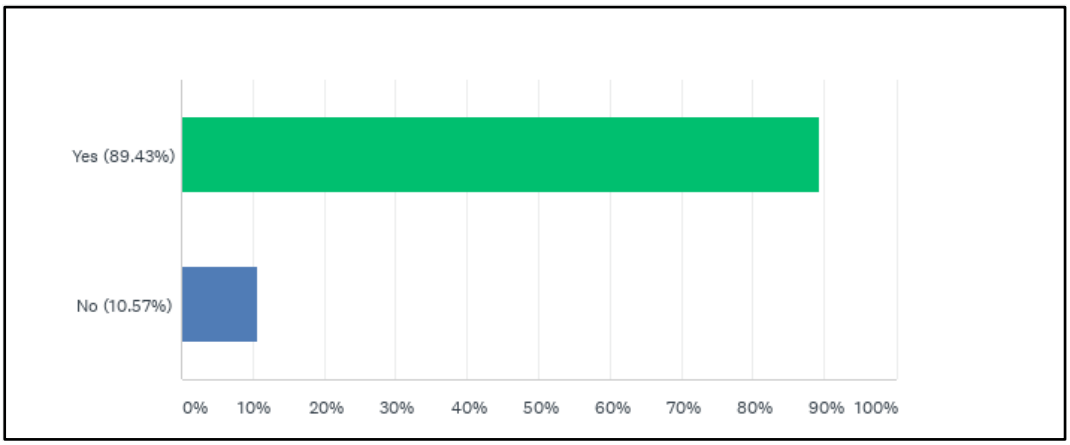
During June 2020, a short anonymous survey was distributed to the Cwm Taf Morgannwg University Health Board midwifery workforce. In total, 125 respondents (over 40% of the midwifery workforce) completed the survey. Respondents from Band 5 to Band 8a+ were represented, in addition to capturing responses from all sites across the Health Board.

Do you have concerns about highlighting incidents via Datix reporting?



Of the 125 responses, 88% of respondents had no concerns around highlighting incidents via Datix. From this, it would appear that there is a shift in culture in respect of identifying and reporting of incidents, with increasing confidence in this process.

Do you feel that you have an adequate understanding of incidents which would require a Datix report?



Overwhelmingly, 89% of staff felt they had the knowledge and understanding of incidents that would necessitate a Datix report being completed. The small

percentage of respondents who felt they lacked understanding highlighted ways which would support them with this.

"An idiot's guide please"

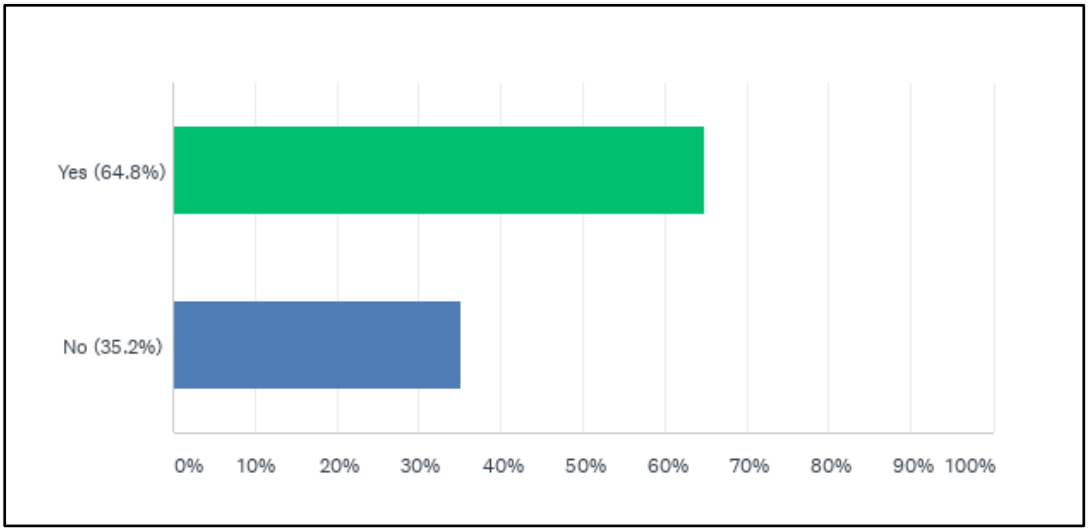
"Possibly an up dated incidents that require datix and knowing where to access list, ? file share"

"It changes quite often. An updated list would be beneficial"

"A printed list that can be easily accessible"

"A comprehensive list in the file of 'notification of birth' or somewhere else could be very helpful"

When you have completed a Datix report, have you received any feedback?



There was a mixture of responses; positively there with more staff indicating that they received feedback from reporting of Datix incidents than those who did not received feedback.

"Yes, it's always been constructive"

"Yes, only received feedback more recently, previously this was not received"

"Yes it will improve the care I give"

"Yes…learning identified clearly"

Some give an indication that there may be some inconsistency of feedback.

"I have received feedback for some and nothing for others, only a few feedback pieces received have been constructive and meaningful"

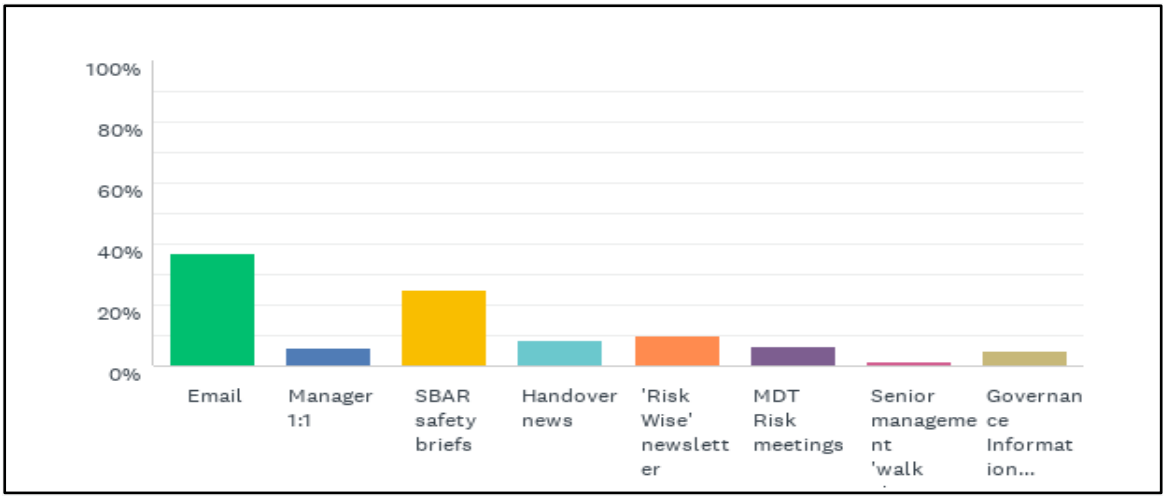
"I feel that we should have more detailed information following the review of Datix. On some occasions I have received this and it has been much more beneficial."

A smaller proportion of staff highlighting concerns around either not receiving feedback, or the feedback given having limitations in respect of constructiveness or meaningfulness.

"Not always meaningful or constructive. Feedback can be helpful to learning provided the arena for learning is available"

"No not constructive. No feedback on how decision was made. It is also sporadic and no ability for staff to access the datix and investigation. This has been highlighted on many occasions on study days with the promise they will look into it. Still awaiting answers"

There is ongoing work around communicating learning from incidents to the whole maternity team. Which processes currently in place do you benefit from?



There were additional responses in relation to this question which offered some insight in to thoughts around communication processes around clinical incidents. There appeared to be positive regard for all the various methods used to communicate learning. Some constructive criticism was also offered.

"Although work is taking place, I still feel that communication is very poor between staff and management"

"Still find communication very poor, management still reluctant to engage with staff on the clinical area"

"I don't feel like I benefit from any of them. I attend the datix meetings but sometimes find they turn into a "blame" meeting"

"Correct information needs to be communicated should be in an informative way still focus on negative things we do rather than positive things we achieve, e.g. recognition from management positive feedback from women, management seem to lose momentum in their recognition of this."

"Many of these, although I don't find the manager walk about helpful as the matron generally tells us what we're not doing well rather than what we are"

Within CTM we are working hard to develop a positive, transparent culture where we are continually learning and continually improving. Do you feel that you are involved and able to contribute to this within your role?

Overwhelmingly, with over 72% of respondents indicating that they felt involved and able to contribute to a positive, transparent culture where we are continually leaning and improving. There appears to be strong feeling from maternity staff that they are already doing this, or certainly looking to contribute to this within their role. There were 29 more detailed responses from individuals which gave further insight into their thoughts.

There were some comments made around a continuing culture of blame.

"Still feel culture is based around blame not learning so I would not volunteer information routinely."

"I don't think we are transparent or positive. I really don't think much has changed in regards to the blame culture"

Other comments allude to a changing culture in respect of a 'blame culture' improving or being something of the past.

"In the past there has been a bit of a "blame culture"

"I do feel the way incidents are dealt with now has improved over the last year, however I do still feel it is a blame culture and midwives are still practicing defensively. I think more group discussions surrounding the case as appose to 1 on 1 discussions would be beneficial"

"In the past there has been a culture of blame. This has improved"

There were several comments made around lack of involvement around the role and work of community midwives.

"I feel the Community midwives are often forgotten as the focus is generally on the hospital"

"Community midwives are continuously last to know anything and are often overlooked"

Some comments around changes being introduced and staff not feeling involved in contribution to this change, but rather being told this was going to happen.

"A large majority of the changes which occur are often fed back through safety briefing or email, where there is no opinion or area for contribution asked, moreover this is the change and this is how it's done"

When Serious Incidents happen, staff are asked for statements regarding their involvement. They may also be required to attend a fact-finding interview to ensure robust and detailed investigation and reporting. If you have been involved in this process, how did you feel about this? Did you get the support you needed? What would have been useful for you during this process?

Respondents were offered the opportunity to provide a free text answer. There were 92 responses to this question with a real mix of responses. Many individuals felt fully and appropriately supported with the level of support offered within this process.

"I don't think anyone finds this a problem, its normal practice now"

"Yes, had the support I needed"

"I had full support"

"Yes I have attended court and have had support from a senior midwife"

"Yes have been involved while ago was supported"

There were several comments regarding statement writing and it would appear staff would welcome further managerial support and assistance around this area.

"There is very little independent support or guidance in writing the statement"

"Some staff felt that managerial support during this process was lacking"

"….I think there is more managerial support needed as the people involved didn't even have a conversation with manager before the MDT review or statement writing"

"No support when involved in a serious incident. The support i received was from my colleagues and not management."

"As a newly qualified midwife it was quite frightening to receive emails requesting information. I would have benefitted with support and reassurance from senior colleagues and managers and guidance with the process. Having someone speak to me directly about the incident would have helped a lot."

"I have not been directly involved but I have supported many staff through this process. In the majority of investigations staff are not supported by management and it has been a punitive experience rather than a learning one. A culture of support would be far more helpful for staff."

Some felt that additional training would benefit staff around areas of the investigation process, statement writing and giving evidence in Court.

"I have felt that this process is very intimidating and can feel threatening. I feel it would be useful to have sessions included in the mandatory training on statement writing investigation processes and what to expect if you are required to give evidence in court"

"A leaflet that explains the normal process and clear guidance on systems for support"

For others, feedback and de-brief following this process was highlighted as being important.

"I've never heard back after submitting statements to be provided with feedback. That would be appreciated"

"Found it very stressful……. Felt upset for some time after. Useful to feedback from these meetings to others who need to attend so that you have an idea what happens"

"I have been involved with serious incident reviews. The process can be very stressful. I do however feel a debrief following the event would be better rather than waiting what feels like an eternity to be held…..I think those would benefit all staff involved with adverse outcome"

Appendix 1

Action Plan

Action		Completion date	MIB work stream	Owner
1	Continue to undertake incident reporting annual updates on midwifery mandatory training days		Safe and Effective Care	Governance and Risk Lead
2	Await publication of All wales trigger list and align HB maternity incident reporting. Develop staff communication	TBC		
3	Improve feedback to datix reporters to ensure it is inclusive of action taken and learning	Dec 20		
4	Improve staff communications to be inclusive of good practice and improvements/learning. Continue to utilise – • Safety briefing • Risk wise newsletter • Governance days Potentially Develop - • Women's weekly (informal weekly newsletter) • clinical café (interactive learning/discussion email)	Jan 21		
5	Senior support to being involved in serious incidents • email requesting statements to include details of how to contact senior governance and operational leads • develop joint operational/supervisor 'clinics' to support staff involved in serious incidents	Dec 20		
6	Develop Staff information leaflet about coroner's court process	Dec 20		
7	Develop 'you said we did' communication to share actions with staff	Nov 20		
8	Roll questionnaire out to medical staff	Nov 20		
9	Repeat questionnaire to assess progress in 6 months	March 21		
10	Add actions to Maternity Improvement Plan	Nov 20		