Terms of Reference - Review of Safety of Cwm Taf University Health Board Maternity Services 2018 Commencing 13 November 2018

This document sets out the terms of reference for a review of Cwm Taf University Health Board maternity services with the aim of describing the quality and safety of the service offered to expectant women and newly born infants, the events leading to the identification of a cohort of serious incident reports, and to provide insight on any improvements required.

BACKGROUND

The maternity service at Cwm Taf University Heath Board identified, in summer 2018, a low rate of reporting of incidents of potential harm. A look back exercise from 1 January 2016 to end September 2018 indicated that a number of clinical incidents had gone unreported. The look back exercise was undertaken to understand if the quality of the investigations undertaken had been robust and in line with the expectations set out in the Putting Things Right arrangements and that any identified improvements had been implemented. A cohort of 43 clinical events was identified, including stillbirths, neonatal deaths and possible harm to mothers and new born infants. Further clinical events identified since the end of September 2018 are being investigated in the usual way, and the external review will include a view on the governance of the investigation and learning from these events.

The key question for the Health Board, Welsh Government, families using maternity services and the general public is the safety and sustainability of the service. The Cabinet Secretary for Health and Social Services requested an external investigation to determine the scale and nature of any patient safety concerns the reasons for these concerns, and what action may be required to ensure safe and effective maternity services in future.

The review is required to identify any situations in which the care provided was below the expected standards, including errors or omissions in care, and whether the organisation and its staff had been supported to learn from mistakes or problems of the past. It is also needed to offer assurance about whether learning has been translated into sustained improvements in safety and quality of maternity services, outcomes for women and newly born infants, system learning and governance within the health board, especially in light of the proposed transfer of service locations in March/April 2019.

PURPOSE

The purpose of this review is to describe the quality, safety, accountability and governance arrangements of the health board maternity services during the period between 1 Jan 2016 to November 2018,

- advise on the need for any review of earlier events,

- and provide insight on what is needed to support the reconfiguration of Cwm Taf University Health Board maternity services in 2019 (in particular the move to Prince Charles Hospital and addition of the Bridgend area).

The review will document from the evidence considered:

- how professional cultures, staffing and skill levels have impacted on clinical practice;
- whether services are woman and person centred, open and transparent and delivered in line with national standards;
- how the Health Board, through its governance framework, gains assurance of the quality and safety of maternity and neonatal services;
- whether appropriate learning is openly shared with service users and staff and incorporated into the service with a focus on continuous improvement;
- whether there are any gaps remaining in practice, governance and accountability.

SCOPE AND OBJECTIVES

- Seek the views of staff, service users, stakeholders, including conducting interviews with key personnel to establish facts and sources of quantitative and qualitative data, including service user views.
- Review relevant Health Board records and documents to consider the performance of the current service, supported by data and where possible benchmarked against national standards.
- Describe and analyse aspects of maternity services and relevant neonatal services, in terms of professional culture, staffing levels and skill mix, skills within the team, clinical practice, routine data collection, incident reviewing and reporting, care pathways, standard operating procedures, safety measures.
- Define and assess the framework of clinical and managerial governance and accountability and how this has changed and developed, making suggestions about adding strength to the current framework if necessary
- Review externally reported data and a random sample of the investigations undertaken of the cohort of 43 cases, subsequently reported incidents, and any others if the review team deem necessary
- Describe the safety and the experience of care provided to women and their babies by the Health Board's maternity and ancillary neonatal services over the time period 1 Jan 2016 to November 2018. However, the review should look back as far as the team determine necessary to understand what has led the recent position.
- Advise on any requirements for extension of the retrospective case review (prior to January 2016) to ensure that the duty to be open and candid to patients has been fulfilled.
- Advise on any quality and safety changes required to care practice and pathways in light of the reconfiguration of Cwm Taf University Health Board maternity services in 2019 (the move of obstetric led care to Prince Charles Hospital and the addition of Princess of Wales Hospital, Bridgend).

- Identify any practical or cultural barriers within the service (or the wider organisation) that might inhibit progress and make recommendations for mitigating actions and improvements.
- Advise on future improvements and maintenance of quality, patient safety and assurance mechanisms

KEY DELIVERABLES

- A descriptive and analytical report with recommendations suitable for publication
- Advice on an assurance framework for quality and safety, which may be transferable to the rest of the organisation and NHS Wales.

MEMBERSHIP

Members of the Review Team to be nominated by the Royal College of Obstetrics and Gynaecology and the Royal College of Midwives, Neonatology and include service user representation.

METHODOLOGY

As agreed between Welsh Government and the Review Team in line with the scope and objectives outlined above, including an inception meeting with Welsh Government. Please also see later section .

EXPECTATIONS FROM THE REVIEW

It is expected that the Review Team will:

- Have regular contact with Welsh Government officials during the process of the review to share any immediate patient safety concerns;
- Escalate any immediate concerns that might be identified during the review process to Welsh Government in real-time so that remedial action can be taken as appropriate;
- Produce a written report with key recommendations for action and improvement as soon as possible after the conclusion of the review that will be agreed with Welsh Government prior to publication. The review report will need to be suitable for publication and as such would need to ensure that no patient or staff-identifiable information is included. The Review Team must ensure that the report is shared with all relevant organisations and individuals for factual accuracy before submitting their final report.

If the Review Team wishes to draw to the attention of Welsh Government any concerns about individuals who could be identifiable, this will need to be included in a separate Annex which would be appropriately excluded from any publication.

Methodology - RCOG Invited Review of Cwm Taf University Health Board

Site visits 15-17 January 2019

1. Review the current provision of care within maternity services in relation to national standards and indicators as well as national reporting.

2. Assess the prevalence and effectiveness of a patient safety culture within maternity services including

    - the understanding of staff of their roles and responsibilities for delivery of that culture;
    - identifying any concerns that may prevent staff raising patient safety concerns within the Trust;
    - assessing that services are well led and the culture supports learning and improvement following incidents;

3. Review the RCA investigation process, how serious incidents (SI) are identified, reported and investigated with the maternity services; how recommendations from investigations are acted upon by the maternity services and 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.

4. Review how through the governance framework the Health Board gains assurance of the quality and safety of maternity and Neonatal services.

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.

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.

7. Identify the areas of leadership and governance that would benefit from further targeted development to secure and sustain future improvement and performance.

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.

9. Consider the appropriateness and effectiveness of the improvement actions already implemented by the Health Board.

10. Make recommendations based on the findings of the review to include service improvements and sustainability, advise on future improvements, future staffing and maintenance of quality, patient safety and assurance mechanisms

Timescales

Who	What	By when
WG	Initiate commission of external review	9 Oct 2018
WG	Draft ToR and share with CTHB	16 Oct 2018
CT	Identify data sets, documentation and key stakeholders	Start of review
WG	Agree ToR , deliverable and timescales, formal commission	13 Nov2018
Review team	Accept commission, costs and report timescale	13 Nov 2018
Review Team	Identify visit dates and stakeholder events	Nov 2018
Review Team	**Review commencement date**	**13 Nov 2018**
WG/ Review Team	Interim progress meeting(s) and safety briefing	Monthly ftf wkly phone
Review Team	Site visit to Cwm Taf Health Board and Bridgend, including public engagement, with immediate verbal feedback and advice to WG and HB to inform service change plans	15-17 Jan 2019
Review Team	Present draft report to WG and CT for fact checking	16 Mar 2019
WG /CT	Factual feedback to Review Team	23 Mar 2019
Review Team	Present final report to WG with recommendations	29 Mar 2019
Cab Sec WG	Publish report and response	April 2019
Health Board	Publish response and improvement plan	April 2019