



INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL

Cwm Taf Morgannwg University Health Board

Quarterly Progress Report
Autumn 2019

FOREWORD

On 30 April 2019, following the publication of a review conducted jointly by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, the Minister for Health and Social Services announced that he was placing maternity services in the former Cwm Taf University Health Board into ‘special measures’.

As part of a discrete but complementary package of measures designed to support his intervention, the Minister appointed an independent panel to provide the oversight which is necessary to ensure that Cwm Taf Morgannwg University Health Board addresses the failings identified by the Royal Colleges’ in a timely, open and transparent manner.

In accordance with its terms of reference, the now entitled, Independent Maternity Services Oversight Panel is required to provide the Minister with regular updates on the progress which is being made in delivering the improvements which are necessary to ensure that maternity services at the former Cwm Taf University Health Board are safe and effective, women and family centred, responsive, well lead and well managed.

This is the Panel’s first formal progress report to the Minister which covers the period from the beginning of May to the end of September 2019.

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Cwm Taf Morgannwg University Health Board

Independent Maternity Services Oversight Panel



Mick Giannasi (Chair) is the Chair of Social Care Wales. He has extensive senior leadership experience and was formerly the Chair of the Board of the Welsh Ambulance Service NHS Trust, a Welsh Government Commissioner for Isle of Anglesey County Council and the Chief Constable of Gwent Police.



Cath Broderick (Lay Member) is an Honorary Fellow of the Royal College of Obstetricians and Gynaecologists and the author of the 2019 report, *Listening to Women and Families about Maternity Care in Cwm Taf*. She has extensive experience in patient and public engagement and supported the response to the Kirkup Inquiry in Morecambe Bay.



Alan Cameron (Obstetric Lead) has 26 years' experience as a Consultant Obstetrician and has recently been appointed as the National Clinical Lead in Obstetrics and Gynaecology for the Scottish Maternity and Children Quality Improvement Collaborative.



Christine Bell (Midwifery Lead) has over 30 years' experience working as a midwife in England, ten of those as a Head of Midwifery and is a designated Midwifery Assessor with the Royal College of Obstetricians and Gynaecologists.

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1 PURPOSE AND FORMAT OF REPORT

The purpose of this report is to summarise the progress which has been made by the Independent Maternity Services Oversight Panel (the Panel) during June, July, August and September 2019, in discharging the terms of reference set by the Minister for Health and Social Services (the Minister).

In particular, it provides an assessment of the progress which Cwm Taf Morgannwg University Health Board (the Health Board) is making in delivering against the recommendations contained within the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM) joint review (for ease of reference called the 'RCOG review') of maternity services at the former Cwm Taf University Health Board (the former Cwm Taf) which includes the Royal Glamorgan and Prince Charles Hospitals.

Where appropriate, the report also highlights the key issues and challenges which are constraining the pace of progress and summarises the actions being taken by the Health Board and/or the Panel to address them. Necessarily, it touches upon a series of wider organisational issues which will need to be addressed in order for the improvements which are required in maternity services to be sustainable in the longer term.

The report is intended as a public facing document and as far as possible, is written in simple language, avoiding the use of technical terms and detailed performance information. As such, it is important to emphasise that the Panel and the Health Board are adopting an evidence-based approach and the conclusions which are set out in the report are supported by more detailed information and analysis. However, in the interest of keeping the report succinct, that supporting evidence may not always be outlined in full in the report. Where that is not the case, and the conclusions are more subjective, this is made clear.

That said, in the early stages of the improvement process, given that the Health Board's programme and performance management arrangements are in the early stages of maturity, there is more narrative based analysis in this first report than the Panel would have liked. The intention is that subsequent reports will be more evidence based as the assurance framework which has been agreed with the Health Board (see **Section 6**) begins to mature.

1.1 REPORT BREAK-DOWN

The report is broken down into sections as follows-

- **Section 2** of the report provides a summary of the background to the Minister's decision to place maternity services at the former Cwm Taf into special measures. This has been kept intentionally brief, given that the Minister has previously reported these matters in some detail to the National Assembly for Wales. In particular, he issued Written Statements explaining the background to the intervention on 30 April 2019 (which can be accessed [here](#)) and on 25 June 2019 confirming the final terms of reference for the Panel (which can be accessed [here](#)).
- **Section 3** of the report explains how the Panel has established itself in order to discharge its terms of reference and summarises the business process which it has put in place in order to hold the Health Board to account for delivery against the agreed Maternity Services Improvement Plan (MSIP). Again, this has been kept intentionally brief given that the Minister made a Written Statement about the establishment of the Panel on 23 May 2019 (which can be accessed [here](#)) and provided a progress update on 16 July 2019 (which can be accessed [here](#)).
- In addition to its responsibilities for providing assurance that the Health Board is delivering the necessary improvements identified by the RCOG review, the Panel has two other responsibilities; firstly, to design and implement a programme of independent clinical reviews and secondly, to support the Health Board in developing effective arrangements for engaging with the women and families who have been or may in the future be affected by the RCOG review. The progress which has been made in each of these areas is summarised in **Section 4** and **Section 5** of the report respectively;
- **Section 6** of the report explains the Integrated Performance Assessment and Assurance Framework which has been agreed between the Health Board and the Panel as the basis for managing and assessing progress. It also explains how the Panel will seek assurance that what it reports to the Minister in terms of progress against the MSIP is backed up by tangible evidence and embedded in operational practice;
- The Health Board has responded constructively to the Minister's intervention and is working collaboratively with the Panel to put the arrangements in place to ensure that the improvements which are required in maternity are delivered. **Section 7** of the report summarises the arrangements which the Health Board have put in place to respond to the Minister's intervention and highlights those areas where further work is needed to ensure that the foundations for longer term sustainable improvement are firmly in place;

- **Section 8** of the report provides the Panel's assessment of the progress which has been made to date in delivering against the recommendations within the RCOG review and other associated reviews and identifies where further work needs to be done. In particular, it highlights some of the wider organisational issues and challenges which are constraining the pace of progress and explains how the Heath Board is responding to those at a corporate level.
- **Section 9** provides an overall summary of the current position and **Section 10** summarises what the Minister might expect to see in terms of further developments in the next quarter.

2 BACKGROUND AND CONTEXT

In October 2018, as a result of growing concerns about the quality and safety of care within maternity services at the former Cwm Taf, Welsh Government commissioned a joint independent review by RCOG and RCM.

As part of their methodology, the Royal Colleges conducted a three day site visit in January 2019 when they spoke to staff and patients about their experiences. They were so concerned about what they found, that they took the highly unusual step of making interim recommendations designed to ensure immediate improvements in patient safety. The eleven 'make safe' recommendations were accepted and immediately acted upon by the Health Board and Welsh Government.

The Royal Colleges' full report, setting out the findings of their review, was published on 30 April 2019. The report highlighted serious concerns relating to:-

- a lack of compliance with national standards;
- safe staffing levels and rotas;
- an inadequate safety culture;
- poor management of and learning from serious incidents;
- ineffective patient engagement;
- poor inter-professional relationships.

These failings were compounded by apparent weaknesses in the corporate governance of quality and safety and inappropriate culture and behaviours which compromised the quality and safety of care being provided.

The report was supplemented by a narrative which told the stories of women and families who had used the service and painted a disheartening picture of patient experience and service quality which fell a long way short of acceptable standards.

The report contained a significant number of recommendations for improvement, all of which were accepted by the Health Board and Welsh Government. This included recommendations that a number of serious incidents which occurred between January 2016 and September 2018 should be the subject of independent clinical review with a further look back exercise to 2010 and potentially beyond.

2.1 WELSH GOVERNMENT RESPONSE

In response to the Royal Colleges' findings, the Minister announced that maternity services at the former Cwm Taf would be placed in 'special measures'.

As part of the escalation process, the Minister announced a number of discrete but complementary measures, namely:-

- the establishment of an Independent Maternity Services Oversight Panel tasked, amongst other things, with seeking robust assurance from the Health Board that the recommendations within the RCOG report are being implemented against agreed milestones;
- the appointment of David Jenkins, the former Chair of Aneurin Bevan University Health Board, to work with the Chair and the Board to enable them to deliver improvements in leadership and corporate governance;
- a programme of support, provided by the NHS Delivery Unit (DU), to enable the Health Board to ensure that there are effective arrangements in place for reporting, managing and reviewing patient safety incidents and concerns.

The Minister also decided to increase the Health Board's overall escalation status to 'targeted intervention' due to the broader quality and governance issues which emerged. Consequently, the Board and its executive team, with external support and overview, have the opportunity to put improvement measures in place for the whole organisation.

In terms of the wider intervention work, Healthcare Inspectorate Wales (HIW) and the Wales Audit Office (WAO) are currently conducting a joint review of the Health Board's arrangements for the governance of quality and safety. In addition to this, HIW has commenced its thematic review programme of maternity services across Wales.

3 INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL

The Panel was established by the Minister on 30 April 2019 to provide the oversight necessary to enable the Health Board to implement the recommendations of the Royal Colleges' report in a timely, open and transparent manner.

The full Panel came together for the first time on 27 May 2019, following a recruitment process conducted by Welsh Government.

The Panel co-opts additional specialist support as necessary and has access to business and administrative support, funded by Welsh Government.

3.1 ROLES AND RESPONSIBILITIES

At the time of announcing that he was establishing an Independent Maternity Services Oversight Panel, the Minister published draft terms of reference which were subsequently amended following a consultation exercise with key stakeholders, including women and families who were affected by the failings which were identified by the Royal Colleges.

Revised terms of reference were published by the Minister on 25 June 2019 in a Written Statement and these have provided the focus for the Panel's work as described in the remainder of this report. The Panel has five key responsibilities which are set out in the terms of reference attached at *Appendix A*. These can be summarised as follows:-

- oversee the delivery of improvement in maternity services at the former Cwm Taf;
- establish and manage a process of independent clinical reviews;
- assist in the development of effective arrangements for patient and staff engagement;
- escalate wider concerns about governance to Welsh Government or the Health Board;
- provide advice to the Minister on any further action which is necessary.

The Panel has adopted a structured approach to its work, drawing on good practice from previous interventions, most notably the Welsh Government's intervention in the Isle of Anglesey County Council, the Tawel Fan intervention and the work which was done in response to the Kirkup Inquiry into maternity services in Morecambe Bay.

The Panel has also worked in partnership with the Wales Centre for Public Policy to ensure that its approach reflects sound academic principles and evidence-based practice of 'what works' to achieve a successful intervention.

Reflecting that evidenced-based approach and, in particular, the principle that an intervention body should provide role modelling leadership to the organisation subject of the intervention, the Panel has developed and widely circulated a set of values and behaviours which underpin the way it operates. A statement of the Panel's values and behaviours is set out in *Appendix B*.

The Panel's key responsibilities have been categorised into three working areas, which involve developing:-

- i. an improvement monitoring and assessment process;
- ii. effective engagement and communication plans;
- iii. a clinical review strategy.

Some challenges faced by the Panel over the next three months will be to further develop a Performance Assessment and Assurance Framework in conjunction with the Health Board, to support them in implementing an Engagement and Communication Strategy and to progress the Clinical Review Strategy from planning to implementation. Each of these is explored further in subsequent sections.

3.2 COLLABORATIVE WAYS OF WORKING

In accordance with its values, the Panel has developed a collaborative relationship with the Health Board. This seeks to minimise unnecessary bureaucracy and duplication of effort whilst providing the guidance, support and encouragement which is necessary to enable the Health Board to deliver, albeit within an environment of robust challenge and scrutiny. The establishment of supportive but challenging relationships at various levels within the Health Board are resulting in improved information flows and a better mutual understanding.

The Panel has also put a significant amount of time and effort into engaging with stakeholders and has consulted widely on its methodology and general approach. This includes regular briefings for Board members and progress updates for the women and families affected by the failings which have been identified in maternity services via a newsletter and face-to-face briefings.

In order to discharge its responsibilities, the Panel has developed a monthly business cycle which is outlined in schematic form at *Appendix C*. This is based around a series of informal weekly meetings and a more formal monthly meeting where the Panel has the opportunity to assess and scrutinise the Health Board's progress. The pace of progress has increased since the appointment of the Panel's Business Manager and the Health Board's Maternity Improvement Director, who jointly manage the oversight process.

In addition, formal meetings are attended by a range of stakeholders as participating observers. This includes representation from the Community Health Council (CHC)

and the Trade Unions. Other agencies involved in the intervention process, such as HIW, WAO and the DU, are also present to ensure that information is shared appropriately and evidence is triangulated.

A constructive meeting was held with representatives from HIW, the General Medical Council and the Nursing and Midwifery Council to gain mutual understanding of each organisation's statement of approach, joint information sharing, collaboration and regulatory support for the Panel. The Panel is also working in partnership with the Cwm Taf Morgannwg Safeguarding Board to ensure alignment with their processes.

4 ENGAGEMENT WITH WOMEN AND FAMILIES

One of the Panel's key responsibilities is to advise the Health Board on the actions it needs to take to establish effective engagement arrangements which actively involve women, families and staff in the improvement of maternity and neonatal services. This includes rebuilding wider public trust and confidence in the Health Board.

The Panel's Engagement Lead has been co-ordinating this area of work and it would be fair to say that there is probably more progress to report here than in any other areas of the Panel's responsibilities.

That is due, in no small part, to the fact that the Engagement Lead was part of the Royal Colleges team which conducted the RCOG review and author of the *Listening to Women and Families about Maternity Care in Cwm Taf* supplementary report. However, it also reflects the fact that she was the first member of the Panel to actively commence work and had already developed relationships of trust with some of the women and families involved as part of her earlier work.

4.1 ENGAGEMENT AND COMMUNICATION STRATEGY

The Engagement Lead has been working closely with the Health Board to progress the work which is necessary to plan, design and deliver an effective Engagement and Communication Strategy, not only for maternity services, but more broadly at the corporate level based on the work which is taking place specifically around maternity services.

This work is not yet fully completed but is progressing well, although there are some barriers to success which need to be addressed if effective delivery of the strategy is to be assured.

In the early stages of the development process, the Engagement Lead was providing much of the momentum for this work, organising and facilitating the workshops and chairing the meetings of what has now evolved into the Women's and Families' Experience Project Board.

The Project Board is supported by a truly multidisciplinary group which includes a number of service users and the new lay Chair of the Maternity Services Liaison Committee (MSLC) which has been revitalised and re-launched.

A number of exercises were organised to enable staff and service users to identify what is currently working well, what needs further development and what should be discontinued. Drawing on local experiences and lessons learned from Morecambe Bay and further afield, a number of strands of activity were identified and this work laid the foundations for the Health Board team to now take a more prominent role in developing the corporate Engagement and Communication Strategy.

The Project Group has now taken responsibility for developing the implementation plan for the evolving Strategy, focusing its efforts first on the design of maternity services and the needs of women and families within it. A work programme has been developed and terms of reference have been produced, formalising the membership and clarifying reporting mechanisms. The Consultant Midwife is now leading the Project Group.

Whilst the corporate Engagement and Communication Strategy is still being finalised, the Health Board has developed an interim engagement approach in response to the RCOG review recommendations which it is hoped will be ratified at the next meeting of the Maternity Improvement Board. The content draws significantly on the feedback from women and families set out in the *Listening to Women and Families* report and focuses on four main areas:-

- Supporting and informing women and families at what is a key time in their lives;
- Listening to women and families and using their experiences to learn and improve on where things didn't go well;
- Providing opportunities to input into service delivery and design;
- Restoring public confidence in maternity services.

The Engagement Lead continues to attend the Project Group to maintain links with the Consultant Midwife and the MSLC to sustain programme oversight. This is helping to ensure that the programme is being delivered on track and that the focus remains on addressing the RCOG review recommendations. However, the willingness of the Health Board to take ownership is a really positive step-forward which is allowing the Engagement Lead to increasingly step back into an advisory role, as was originally envisaged.

As part of the work which is being done to develop the Integrated Performance Assessment and Assessment Framework, the Project Group is developing a self-assessment tool which will enable the Health Board to track levels of maturity and to identify improvements in the quality of service experienced by women and families. The feedback from this process will generate further evidence to support a deepening understanding of the change in approach which is needed to fully embed and sustain engagement and communication.

4.2 COMMUNITY ENGAGEMENT EVENTS

One of the key deliverables emerging from the corporate Engagement and Communication Strategy is a series of community engagement events. The first two events will be held in November 2019 with a further event being planned for early in the New Year. These events are intended to demonstrate the Health Board as an open, transparent organisation which genuinely wants to engage and involve women and families in the design and delivery of its services.

The team are working with external experts to utilise visual mapping techniques together with a range of innovative engagement approaches. These events will provide valuable opportunities to engage with the wider communities. They will take place in local community settings and are being designed to identify the key issues for women and families in maternity services and gain an understanding of 'what good looks like'.

The planning and implementation of these events will also strengthen organisational capability, building the skills and experience of participating staff through facilitation and communication with their local communities and families. This will strengthen relationships, and start to rebuild public trust and confidence in using Health Board services.

The commitment of resources to support the community engagement events, and the more focused project planning around engagement and communication for maternity services are important steps forward which signal increased ownership and responsiveness of the Health Board in developing more effective approaches to patient and public engagement and communication.

4.3 STAFF ENGAGEMENT

Progress is also being made on the approach to staff engagement, communication and leadership development. A 'Let's Talk' programme has been developed with the interim Chief Executive Officer (CEO) and other members of the senior leadership team undertaking a series of listening sessions. An external provider has also been commissioned to work with staff, patients and partners to understand and reset the organisation's values and behaviours.

4.4 AREAS FOR DEVELOPMENT

Although progress has undoubtedly been made in terms of developing the Health Board's approach to engagement and communications, there are some issues which need to be addressed as a matter of priority, if that progress is to be sustained and built upon, namely:-

- an identified lead within the senior leadership team who takes overall responsibility for the development of the Health Board's Engagement and Communication Strategy to prevent continued lack of co-ordination at corporate level;
- although the Health Board staff involved in this area of work are highly committed and enthusiastic, there are some gaps in both capacity and capability, particularly in relation to the skills required for co-production and for engaging with families experiencing adverse events;

- whilst the necessary capability, skills and experience may be available within the wider organisation, the additional work needed to get the maternity services engagement programme off the ground will require careful job planning to avoid already busy people becoming over-burdened and additional capacity and expertise may be needed, particularly in the early stages;
- currently, engagement with women and families does not consistently happen at a service level in any meaningful or organised way and staff may have lost skills and confidence to address concerns and facilitate conversations with women and families about their experience;
- the products of engagement, including feedback from surveys and the comments and conversations on social media are not fully analysed and consequently the emerging themes whilst picked up at some levels are not yet sufficiently influencing the improvement, quality and safety of maternity services.

4.5 HEALTH BOARD ACTIONS

The interim CEO has recognised that these issues are broader than maternity services and that a corporate response is required. The Engagement Lead is supporting the interim CEO in developing a package of measures to address them which includes the following actions:-

- as a matter of urgency, allocate a senior level leadership post which will bring together the patient experience, community engagement and communication strands of planning and activity; the role should be of sufficient seniority to transform the interim engagement approach in maternity service into a cohesive programme at organisational level;
- strengthen team capability by identifying staff with the right experience and skills in specialist engagement techniques, including co-production within the team, providing training and support and ensuring that there is sufficient capacity rather than adding roles on to the jobs of staff already under strain and overloaded;
- involve staff in the co-production of community events and support skills development in designing and delivering engagement, communication and facilitation in challenging circumstances - this can be taken forward into a future programme of community-based engagement;
- as a priority, focus on the development of skills for staff in responding to concerns and identifying issues emerging from engagement at service level;
- address the lack of skills in systematic thematic analysis to ensure that emerging themes are reported and form part of the triangulated evidence for action, to improve quality and safety of maternity services;

- the Patient Advice and Liaison Service (PALS) real-time surveys have potential for wider development with community midwives potentially conducting qualitative interviews;
- training and support for all staff in facilitation skills is required. The PALS team needs to be expanded to ensure that the real-time programme fulfils its potential and drives change;
- the impact of these measures needs to be reflected in the 'Quality of Women's and Families' Experiences' domain of the Panel's assurance framework.

The Panel has also raised concerns with the interim CEO about the organisation's capacity and capability to manage maternity services related complaints and concerns through the 'Putting Things Right' (PTR) process. The DU work and review of complaints and concerns handling appears to have identified very similar issues around PTR and patient feedback management at a corporate level.

The Panel has become increasingly aware that there has been a rise in the numbers of complaints and concerns about maternity services since the RCOG review was published and the intervention process has meant that the current team are overburdened, resulting in fragility within the team.

Consequently, there is a growing backlog of concerns and unresolved cases awaiting investigation, with increasing response times. A number of cases have not been concluded to the satisfaction of the women and families involved and in a small number of cases within the Panels direct knowledge, there has been an irrevocable breakdown of trust.

Feedback from women and families who are contacting the Panel for an independent perspective to resolve their continuing concerns, emphasises the problems shared by staff. The need for urgent action to address this issue has been recognised by the interim CEO and corrective action is currently being taken at a Health Board level.

5 INDEPENDENT CLINICAL REVIEWS

The Panel's Clinical Review Strategy has now been agreed with Welsh Government and the Health Board. The Strategy establishes a framework for the independent clinical review programme and sets out detailed inclusion criteria for the initial phase of the work.

The strategy is available in full and will be published alongside this report. The content is largely self-explanatory and it is not proposed to repeat it here other than to highlight the key issues which will be of interest.

The purpose of the Strategy is to ensure that:-

- a robust clinical review process is in place;
- identified findings or themes from the review process are reported back to the Health Board to enable learning and improvement;
- mechanisms are in place to enable cases to be reported to external bodies where required;
- lessons are being learned by the Health Board through the review of evidence to improve the safety, quality and responsiveness of the maternity service;
- women and their families are engaged in the process (where they so wish);
- staff are engaged in the review process and feedback is given regarding the outcome;
- women and families can have confidence in maternity services provided at the former Cwm Taf.

5.1 CLINICAL REVIEW GROUPS

There are four groups within the look-back review process:-

1. The 01 January 2016 - 30 September 2018 cases identified in advance of the RCOG review (referred to as the 43).
2. The 01 January 2016 - 30 September 2018 cases subsequently identified using an agreed inclusion criteria.
3. The 2010 to 2016 look-back. The criteria utilised for this group will be determined using the outcomes from the above two cohorts.
4. Those women and families who have self-referred will have a review of their care regardless of whether or not they fit the inclusion criteria.

Priority will be given in the order they appear above, however some self-referred cases may fall within the other criteria and hence will be considered within the relevant group.

5.2 INCLUSION CRITERIA

The main focus of the current iteration of the Clinical Review Strategy is to provide the framework which will enable the work to commence on the review of cases which occurred between 01 January 2016 and 30 September 2018 (the 2016-2018 look-back).

Although the Health Board identified 43 cases during this time period, these were not reviewed in depth by the RCOG reviewers, they simply commented on the process being used. As such, the Panel has effectively started with a 'blank sheet of paper' and adopted an inclusion criteria-based approach which encapsulates the 43 cases identified by the Health Board prior to the RCOG review but goes broader and deeper to ensure that as much learning is extracted as possible, bearing in mind that there may well be good practice identified as well as areas for improvement.

The inclusion criteria which the Panel has set for the 2016-2018 look-back is as follows:-

- all 'MBRRACE' reported cases;
- all 'Each Baby Counts' cases;
- all maternal admissions to the Intensive Care Unit (ICU).

The Health Board was presented with the inclusion criteria on 06 August 2019 and they are working towards finalising all the cases which fall within this timeframe. Further detail regarding the cases included within these criteria can be found within the Clinical Review Strategy.

In addition to the above criteria, in order to ensure wider learning, all cases (approximately 350) where mothers and babies were transferred out of the unit in which they were initially being treated have been assessed and evaluated by the Panel's clinicians to determine whether a clinical review is necessary.

Given the marked increase in the scope and breadth of the independent clinical review process and from the work to date, it is anticipated that around 150 cases will be reviewed as part of the 2016-2018 look-back. The Health Board are still quality assuring this figure and therefore it remains an estimate. It is important to stress that these cases are not all serious incidents but have been identified as requiring a review of care to maximise learning.

The clinical review process has been designed as an iterative process and it may be that, depending on learning, a small number of additional cases will require clinical review as the work progresses.

In all cases, women and families affected will be contacted and will be given the opportunity to contribute to the review if they so wish and offered appropriate support as needed.

The agreement of the Clinical Review Strategy and the scoping of the first substantial phase is a significant step forward which will enable the clinical review programme to commence during the autumn.

5.3 POST OCTOBER-2018 INCIDENTS

Another element to the clinical review process is the quality assurance of serious incidents which have occurred since 01 October 2018.

The work to quality assure these recent cases commenced on 16 September. The majority of the investigations that were assessed demonstrated good multi-disciplinary involvement and good engagement with families. There was evidence of robust learning in some of the cases from the action plans. However, the scope of the preliminary assessment was limited due to the number of outstanding cases. On that basis, the process could not be concluded and a further assessment will be undertaken in due course.

5.4 SELF-REFERRALS

It is apparent that whilst all of the cases will need to be reviewed, not all of them will necessitate a full clinical review. The Health Board will propose a way forward for each individual case which will be presented to the Panel for agreement.

Regardless of whether the cases are suitable for clinical review, the Panel will continue to monitor each individual case to ensure that wherever possible a satisfactory resolution is achieved which addresses the needs of the women and families involved.

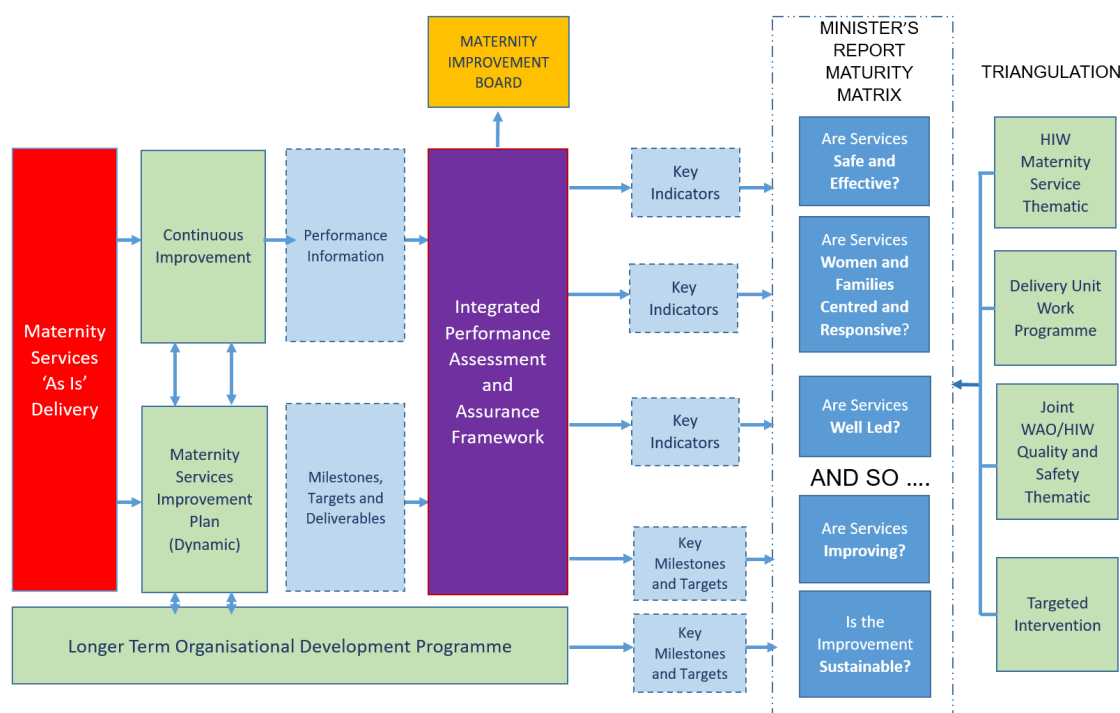
The Panel understand that the triaging process for self-referrals is nearing completion and expects to receive an update at the next Panel Meeting on 21 October 2019. Once the outcomes of the triaging process are known, contact will be made with the women and families involved to discuss and agree the way forward.

6 ASSURANCE FRAMEWORK

Through a series of meetings, culminating in a multi-agency workshop on 12 August 2019, an evidence based Integrated Performance Assessment and Assurance Framework (IPAAF) has been now agreed between the Panel, the Health Board and Welsh Government.

The IPAAF will form the basis of future reporting to the Minister as well as providing the basis of the Health Board's internal performance management and improvement arrangements through the Maternity Improvement Board (MIB) to the Health Board's Quality, Safety and Risk (QSR) Committee.

The framework is outlined in the diagram below. A larger version is attached at *Appendix D*.



The underpinning principle of the framework is that the Panel will utilise the same performance information to seek assurance as the Health Board uses to manage and continuously improve the operational delivery of maternity services and the implementation of the Maternity Services Improvement Plan (MSIP).

Much of the performance information required to populate the framework will be drawn from the Health Board's existing Maternity Services Clinical Governance and Performance Dashboard which is used as the basis for the weekly maternity

monitoring meeting between the Health Board and Welsh Government. Where gaps exist, for example around patient experience, new measures will be developed.

The assurance element of the framework will utilise a five level maturity matrix-based approach to demonstrate the extent to which the Health Board is making progress in three domains, by seeking to answer three key questions, namely:-

- Are services safe and effective?
- Are they women and families centred?
- Are they well led and well managed?

Those judgments will then be utilised to answer two further questions, namely:-

- Are services improving?
- Are those improvements sustainable?

Each of the framework's domains will be populated by a suite of quantitative and qualitative performance indicators and a series of milestones and deliverables aligned to the MSIP.

The assurance framework is consistent with the approach utilised by HIW and will enable line of sight between the Panel's assurance mechanisms and the thematic inspection work which is being undertaken by HIW. It will provide a simple but effective way to report progress while avoiding the overuse of statistics and traffic light systems.

The Panel will supplement the evidence drawn from the IPAAF by conducting monthly assurance visits to test out the evidence of progress which is being provided by the Health Board. The information will be triangulated with intelligence from other elements of the intervention process and the progress in the delivery the Health Board's corporate development programme to develop a rich picture of the extent to which services are improving and the Royal Colleges' recommendations are being delivered.

The assurance framework is in the early stages of development. However, it is anticipated that it will be fully populated by the time the Panel reports in December and a baseline will have been developed to enable progress to be assessed and monitored going forward. For this report, a more narrative assessment of progress is provided although there has been a particular focus on assessing the evidence base to demonstrate delivery against the eleven 'make-safe' recommendations within the RCOG review. This is explored further in **section 8**.

7 HEALTH BOARD RESPONSE

During the early stages of the intervention, the Health Board responded positively and decisively to put a framework in place to respond to the RCOG review's recommendations.

The MSIP was developed and a Director led work-stream structure was put in place to deliver it. The newly appointed Director of Nursing, Midwifery and Patient Care was assigned as the Senior Responsible Officer (SRO) for the Maternity Services Improvement Programme and a programme management framework was put in place. The SRO has provided strong and visible modelling leadership which has started to have an impact on patient experience and staff behaviours as evidenced through increasingly positive patient surveys.

A constructive working relationship was developed between the Panel and the SRO which enabled early progress to be made in establishing the business processes which underpin the intervention.

The Panel met with the Board at the end of June 2019 and it was agreed that a high level delivery mechanism was necessary to ensure that improvements in maternity services were delivered in the context of a broader organisational development plan which addressed some of the underlying factors. For example, organisational culture and behaviours, clinical governance, patient engagement and the management of concerns.

7.1 TIMELINE OF PROGRESS

Some early progress was made in delivering against the recommendations with the MSIP and there were signs that the service re-configuration which had taken place in March, together with the introduction of new leadership at departmental and organisation level was starting to have an impact.

However, from the beginning of July, the pace of progress began to falter, predominantly because the programme resources which were necessary to deliver the MSIP were not yet in place. A number of important pieces of preparatory work, for example the development of the Woman and Families Database and the development of an Information Sharing Protocol were not delivered within the time-scales agreed. This loss of momentum was raised at CEO and Board level and a concerted effort was made to get back on track.

Following the issues experienced during July with the pace and impact of progress, on balance, August and September have been much more positive months. That is due in no small part, to the fact that a number of key appointments have come to

fruition, not least the Maternity Improvement Director (MID) and the Panel's Business Manager.

Both post holders commenced work in earnest in the middle of August. Since that time there has been a marked improvement in the pace of delivery and a number of important developments have taken place, most notably:-

- an outline IPAAF has been agreed and is now being developed further to include the completion of the maturity matrix and the population of the domains with metrics and deliverables;
- the MIB arrangements and in particular the work stream structure that supports it have been reviewed and enhanced to bring them into alignment with the IPAAF;
- a process has been agreed in outline which will enable the Panel to gain assurance about the delivery of the plan through a series of scheduled monthly 'collaborative check-ins';
- there is a commitment that within the next six to eight weeks, the remainder of the MSIP will be re-focused and re-prioritised with SMART action plans and clear milestones, targets and deliverables;
- purposeful conversations have taken place which will enable progress to be made around longstanding issues including the Information Sharing Protocol, the Women and Families Database and the development of the road-map for self-referrals and associated support arrangements for the clinical review process;
- there are signs that the Health Board is starting to understand and take ownership of the engagement and communication work-stream;

The appointment of the MID has been a significant development and that has resulted in a noticeable 'gear change' not only in the pace and impact of delivery but also in the added sense of clarity, cohesion and administrative discipline which has been brought to the process. Whilst there is still much to do and there is still significant progress to be made, the signs are encouraging and it is encouraging to see what the MID has achieved so far.

One positive development during the August has been the inclusion within the IMSOP business cycle of an interim monthly meeting between the SRO, MID, Chair of IMSOP, IMSOP Business Manager and Welsh Government Lead which provides a forum for planning the monthly formal meeting and agreeing priorities. The first meeting took place in early September and resulted in a clear agreement about what the priorities were in preparation for the publication of this report.

One of the priorities which emerged from that meeting was the need to develop an evidence-based approach to assurance starting with the eleven make safe recommendations being an absolute priority.

7.2 FOUNDATIONS FOR IMPROVEMENT

There is clearly a long way to go before a systematic assurance process can be relied on as the basis for reporting to the Minister. However, there are further 'green shoots' of improvement which although they cannot be definitively evidenced, suggest that maternity services are moving in the right direction. Those 'green shoots' include:-

- continued improvements in the Health Board's patient feedback processes which indicate good levels of satisfaction and a reduction in negative comments about staff attitudes and behaviours, particularly during the night;
- a more favourable review from the Health Education and Improvement Wales (HEIW) in respect of the training environment albeit that there still remains a significant amount of work to do.¹

In addition to the obvious improvements which have taken place in the management of the improvement programme, a number of other important building blocks have been put in place which mean that the foundations for sustainable longer-term improvement are now being developed, for example:-

- permanent appointments have been made in the roles of Clinical Director and Service Manager whilst the Head of Midwifery role has been enhanced and re-advertised as a Director of Midwifery;
- a new Medical Director has been appointed and a meeting has been held with the Panel's Obstetric and Midwifery leads. It is anticipated that this will lead to enhanced medical leadership in the improvement process;
- the interim CEO's wider organisational development plan has started to take shape and a number of early developments such as the Board Development Programme, the Executive Leadership Development Programme and the 'Let's Talk' Programme are coming to fruition.

¹ The original published report has been amended to remove an inaccurate reference in paragraph 7.2 which attributed comments about improvements in the training environment for student midwives to the Nursing and Midwifery Council (NMC). Although this reference was based in fact, it was inaccurate in that the comments were wrongly attributed to the NMC. The nature of the process from which the comments emanated was also overstated as a 'review' when it could more accurately be described as a meeting to check progress.

7.3 BARRIERS TO SUCCESS

Against that background, there are still a number of organisational process and systems which are problematic and which will, if not addressed, continue to have a detrimental impact on the pace and sustainability of progress in maternity services. Not least amongst those is the organisation's capacity and capability to effectively manage patient feedback and to respond in a timely way to concerns and complaints received from patients and families.

Over the past month, through the engagement work which the Panel's Engagement Lead has been supporting and the triangulation of the Panel's work with the findings of DU work, it has become increasingly clear that there are significant deficiencies in this area. These issues are a barrier to progress in improving maternity services and need to be addressed as a matter of urgency. In fairness, this has already been recognised by the interim CEO who is actively developing a corporate response to the situation as part of a broader review of strategic communication and patient and public confidence.

The Chair of the Panel meets regularly with the interim CEO to ensure that there is co-ordination between the maternity services improvement and the wider organisational development plan. A significant amount of strategic work is being initiated around three key areas, namely:-

- leadership and culture;
- trust and confidence; and
- quality and governance.

Notably, work is commencing to create new organisational values and behaviours using a tried and tested approach adopted elsewhere within the NHS in Wales. The programme infrastructure which has been established, is part of a wider health board drive to start to embed a new operational model, behaviours and culture that will drive improvement and ultimately make those improvements sustainable. This is underpinned by development programmes to further strength organisational capability moving forward. There does now appear to be an increasing emphasis on public and staff engagement and the desire for a culture of openness and transparency that is a clear move away from the more punitive culture of the past.

8 ASSESSMENT OF PROGRESS AGAINST THE MATERNITY SERVICES IMPROVEMENT PLAN

When the Panel next reports to the Minister in December, it is intended that the three domains of the IPAAF will be fully populated with metrics and deliverables and the maturity matrix which supports it will have been developed and tested. As such, it is envisaged that an objective, evidence-based assessment of the progress which the Health Board has made in delivering against the MSIP can be provided.

In the meantime, it was felt important, four months into the intervention, that an objective assessment of the progress which has been made against the MSIP was provided, albeit that at this stage, it will be more narrative based than the Panel would have liked.

In the last month, the Panel and the Health Board have focused significant effort into securing the evidence which is necessary to provide assurance that the eleven 'make-safe' recommendations identified within the RCOG review have been addressed and the outcomes embedded in operational practice.

8.1 ELEVEN 'MAKE-SAFE' RECOMMENDATIONS

The eleven 'make-safe' recommendations are set out in the table at *Appendix E*. This also includes an assessment of whether, on the basis of the evidence available, the issue is considered to be fully addressed and embedded in operational practice or whether it remains work in progress. The table also shows what evidence has been used as the basis for the assessment and where the action if not fully delivered provides an indication of what more needs to be done before the matter can be recorded as fully delivered.

It will be seen from the table that the Health Board considers that there is tangible evidence to demonstrate that eight of the eleven issues are considered to be delivered whilst three remain work in progress. This position was reported via the MIB to the Health Board's QSR Committee on 05 September 2019. The Committee scrutinised the evidence which was available and concluded that it was reassured that what was reported was a reasonable assessment of the current position. Where issues remained work in progress, the Committee was satisfied that there was a reasonable explanation why that was the case and mitigation in place to ensure the provision of safe services.

In respect of issue number six (**lack of awareness and accessibility to guidelines, protocols, triggers and escalations**) there is evidence to show that the guidelines, protocols, triggers and escalation measures are readily available and that staff have been made aware of them. However, whilst the situation is much improved, the

Health Board is not fully assured that they are routinely being applied in practice by every member of staff and as such, there is further work to be done. There is evidence to demonstrate that there is a systematic approach to addressing this issue. For example, regular management and supervisory review, action plans and management intervention. It is anticipated that there will be sufficient evidence to record this as fully addressed by the time the Panel reports in December.

Issue number ten (**midwifery staffing levels**) remains work in progress because the Birthrate Plus review which has been commissioned to determine minimum safe staffing levels is not due to report its findings until mid-October 2019. However, in the meantime, interim minimum staffing levels have been agreed with Welsh Government and these are routinely being monitored by the Health Board in real time through the maternity services performance dashboard and from a governance perspective via the MIB and QSR Committee. There is also external scrutiny via the weekly maternity monitoring meeting with Welsh Government. In combination, these measures are enabling the Health Board to obtain assurance that the agreed staffing levels are being applied and that where there are shortfalls, the escalation measures which have been agreed are being implemented.

Issue number eleven (**culture within the service**) remains work in progress and is likely to do so for the foreseeable future; it is unrealistic to expect that longstanding issues related to culture, attitudes and behaviours can be addressed within a few months. The Health Board has put in place a series of actions at departmental and organisational level to develop a more appropriate cultural environment but these will take time to plan, develop and deliver and will take even longer to impact. There are signs that the actions which have been taken so far are beginning to have an influence. For example, the weekly surveys which assess the experience of women who use the service are now showing consistent improvements in the levels of satisfaction and marked reductions in negative feedback. However, it is too early to suggest that the cultural issues described in the RCOG review have been addressed. Indeed, conversations with staff suggest that there is still a long way to go.

8.2 'COLLABORATIVE CHECK-INS'

The Panel are undertaking monthly 'collaborative check-ins' within the Health Board as part of the process of triangulating hard and soft intelligence and data around neonatal and maternity services. These visits commenced on Tuesday 17 September 2019, providing an opportunity for the Panel to observe services and teams in action and allowing Panel Members to conduct their own assessment of the progress which is being made against the delivery of the MSIP.

The 'collaborative check-ins' will be designed to mirror the three domains of the IPAAF. These are Safe and Effective Care, Quality of Women's and Families'

Experience and Quality of Leadership and Management. The visits also draw on the four themes of the '15 Steps for Maternity', a toolkit widely used in NHS which can be accessed [here](#). The four themes are as follows:-

- welcoming and informative;
- safe and clean;
- friendly and personal;
- organised and calm.

The first visit was necessarily broad, covering The Antenatal Unit - Day Assessment Unit, Antenatal Triage and Labour Ward. The Panel targeted some key areas of the eleven immediate 'make safe' recommendations of the RCOG review to test the assurance given by the Health Board with regard to these. The summary findings are captured in *Appendix F*. Following the visit, the Panel are reasonably assured that the Health Board's assessment of progress is accurate. Future visits and formal meetings will provide an opportunity for this assurance to be definitively validated.

Subsequent visits will target key areas where the Panel members wish to test the assurance given or to undertake a 'deep dive' into areas to understand impediments to progress. They will also include an increasing focus on women and families experiences as well as staff engagement, to test culture and 'how things feel around here'. Specifically, there will be opportunities for women, families and staff members to talk to the Panel.

8.3 OVERALL DELIVERY

Although the eleven immediate 'make safe' recommendations are clearly a priority, the Panel felt that it was important to provide a sense of the overall position in delivering against the MSIP.

The plan contains 79 actions in total. Of those, 70 derive from the recommendations within the RCOG review and three are actions identified through a self-assessment of Board level governance and leadership which was conducted following the publication of the review. The remaining six actions arise from the Health Board's assessment of the actions which are necessary to meet the principles of the *All-Wales Maternity Vision* which has recently been published by the Minister.

76 of the 79 actions have been allocated to one of the three Project Groups which have been established by the MIB. The remaining three are being managed at Board level. As of 20 September 2019, the Health Board reported that work had commenced to deliver against all of the 79 recommendations.

The charts at *Appendix G* show the proportion of actions which are recorded as completed and those which remain work in progress. The charts also show how the actions are distributed within the various Project work-streams.

This suggests that 24 (30%) of the 79 recommendations have been recorded as delivered whilst 55 (70%) remain work in progress. The 24 completed actions include eight of the eleven 'make-safe' recommendations which are recorded as completed.

It is important to note that, other than for the eleven 'make-safe' recommendations, the Health Board has not yet completed the assurance work required to evidence that the remaining actions have been delivered and also embedded in operational practice. This work will take place in the autumn and a more evidence-based assessment will be available by the time the Panel reports in December.

The charts at *Appendix G* are provided at this stage as a broad indication of the progress which the Health Board is making in addressing the recommendations and should not be viewed as a definitive statement of what can be absolutely assured at this stage.

9 CONCLUSION AND RECOMMENDATION

It is four months since the Minister announced that he was placing maternity services at the former Cwm Taf into special measures.

The Health Board has responded positively to his intervention and, after a slow and sometimes faltering start, is now beginning to make progress in delivering against the MSIP which has been established to address the recommendations contained within the RCOG and other associated reviews.

The foundations for improvement are now largely in place. However, there remains a significant amount of work still to be done and the pace of progress needs to be increased incrementally as the capacity to deliver improvements becomes available.

The Health Board has worked collaboratively with the Panel to put the necessary systems and processes in place to enable the progress against the MSIP to be monitored and assessed. An evidence-based IPAACF has been agreed which will form the basis of future reporting to the Minister.

This will enable the monitoring of improved outcomes over time, and will provide the basis for more meaningful comparison of maternity services provided in the Health Board against those provided in other areas. It is anticipated that the IPAACF will be populated with key metrics and deliverables by the time of the Panel's subsequent Quarterly Report. A baseline will have been established which will enable progress to be assessed on the basis of evidence and outcomes going forward.

In terms of independent clinical review, a strategy has been agreed and the first phase of the process (the 2016-2018 look-back) has been scoped with a wider focus and greater depth than originally proposed by the RCOG review team.

With the assistance of the Royal Colleges, the multidisciplinary teams required to undertake the clinical reviews are being recruited and are expected to begin their work during the autumn. In the meantime, the Panel's clinicians have begun the process of quality assuring serious incidents which have been reported since October 2018. Although there were some encouraging signs of progress, the review was inconclusive and further work is required.

In terms of engagement with women, families and staff, a significant amount of preparatory work has been undertaken which is now moving towards implementation. An engagement and communication strategy has been developed, the MSLC has been revitalised with a Lay Chair and increased service user membership, and a series of engagement events are planned to commence in November, bringing women and families together with staff for the first time to co-produce an enhanced maternity service for the future.

The Health Board is taking ownership of the engagement and communication work and the Panel's Engagement Lead is stepping back into an advisory role. However, there are still significant gaps in the Health Board's capacity and capability to undertake effective patient engagement and to manage complaints and concerns. These deficiencies are being addressed by the Health Board as part of the wider organisational development plan.

9.1 CURRENT POSITION

In summary the current position is:-

- there is now a better understanding of the problem and the underlying causes of poor performance in maternity services have been identified. Much of the work which needs to be done to address these problems both at departmental and organisational level is still in the early planning stages;
- with the support of the Panel and others involved in the intervention process, the Health Board has recognised that the challenges it faces are perhaps deeper, broader and more fundamental than the RCOG review highlighted. A wider organisational development process has been established which will increasingly 'wrap around' the Maternity Services Improvement Programme to ensure that the progress being made is sustainable in the longer term;
- the foundations for improvement in maternity services, including the right leadership, the MSIP, a delivery mechanism and a wider organisational development plan are now largely in place. However, there are still gaps, for example the need to appoint a Director of Midwifery, further recruitment of programme management resources and further development of the MSIP which are in the process of being addressed;
- importantly, there is evidence to suggest, with a reasonable degree of assurance, that the eleven 'make safe' elements of the MSIP have been or are being addressed. In addition, there are 'green shoots' of improvement in other important areas like staff attitudes and behaviours and patient satisfaction;
- it is encouraging that the reconfiguration of services, specifically the consolidation of the consultant led service into PCH that took place in March 2019, has been achieved without obvious negative consequence. This merger appears to have been the catalyst for improved inter-disciplinary relationships and improved ways of working, for example, in terms of safety briefings and patient handovers.

There is still a very long way to go to deliver all of the recommendations within the MSIP. In order to achieve this, further capacity and capability needs to be built in key areas like programme management, quality and safety governance, the management of complaints and concerns, patient engagement and corporate communications. Greater pace, better administrative discipline and greater cohesion at team, departmental and corporate level is also required.

While there are early signs that behaviours may be improving, feedback from staff and patients suggests that there remains a need to change the underlying culture and values which were so shockingly revealed in the *Listening to Women and Families* report.

The issues which the RCOG review identified are longstanding, deep-seated and structural. They will take time to resolve and the results will not be seen immediately. By way of example, the journey in Morecambe Bay from 'special measures' to 'good' - which is the shared ambition for the Health Board - took six years to achieve.

In summary, whilst there are encouraging signs of progress and the foundations for improvement are now largely in place, it is too early to provide the assurance which the Minister and the women and families of the former Cwm Taf need in order to be confident that all necessary improvements have been achieved to ensure sustainable safe, effective, patient centred, responsive, well managed and well led services.

10 NEXT STEPS

The Panel is next scheduled to report formally to the Minister towards the end of December 2019. The oversight process is bedding in and foundations for improvement are now largely in place. In addition, the resources required to deliver improvement are increasingly becoming available and maternity services are becoming integrated into the much broader organisational development plan. Given these factors, it is expected that the pace of progress will accelerate over the next three months.

It is also envisaged that the Panel's next report will be more evidence based with less reliance on narrative to provide an indication of progress. There will also be the opportunity to triangulate the Panel's assessment of progress with the findings of reviews which are being undertaken by other bodies, for example the Review of Quality and Safety Governance being jointly carried out by WAO and HIW, additional inspection work carried out by HIW as well as assessments carried out by other stakeholders including the DU, the CHC and HEIW.

Based on the current position and the work which is being planned, it is hoped that the Panel will be able to report the following key developments by the end of December 2019:-

- the remaining leadership gaps (in particular the substantive Director of Midwifery position) will be filled and the programme resources required to deliver the MSIP will be fully in place;
- there will be greater medical involvement in the improvement process following the recent appointment of the Medical Director and the Clinical Director for Obstetrics and Gynaecology;
- the MSIP will have been developed further with more granularity, better prioritisation of actions and clearer milestones and deliverables;
- further progress will have been made against the three 'make-safe' recommendations which are not yet fully complete and, in particular, the Birthrate Plus review of staffing levels will have been completed and an action plan formulated if required;
- an evidence base will be available to enable progress against the remainder of the recommendations to be assessed and a more robust level of assurance provided;
- the IPAAF will be developed further - the three domains will be populated with key metrics and deliverables and a baseline will be established which will provide the basis for progress to be assessed moving forward;
- the Health Board will have begun to deliver upon the corporate development plan which is currently being drafted and work will have commenced in areas critical to maternity service improvement, including leadership, culture and values;

- progress will have been made in addressing some of the underlying system and process issues which are currently inhibiting progress such as the management of complaints and concerns and the management of patient feedback;
- the Health Board's Engagement Strategy will move from planning to implementation and the first community based co-production events involving staff and patients will have been held and evaluated;
- given that the number of cases to be reviewed is now better understood, Welsh Government is commencing the procurement of clinical review teams via the Royal Colleges to enable the first phase (the 2016-2018 look-back) of the Clinical Review Strategy to begin;
- further work will have been done to quality assure the post-October 2018 serious incidents with a view to validating the Health Board's capacity and capability to work independently in this regard moving forward.

This is a stretching agenda which will require a significant improvement in pace, administrative discipline and cohesion at local, departmental and corporate level. However, the Panel believes that the Health Board now has the right leadership and the necessary processes in place to enable that to happen and looks forward to the next period.

11 LIST OF APPENDICES

Appendix A - Terms of Reference

Appendix B - Statement of Values

Appendix C - IMSOP Business Cycle

Appendix D - Integrated Performance Assessment and Assurance Framework

Appendix E - Summary of Evidence - Eleven 'Make Safe' Recommendations

Appendix F – Collaborative Check-In Themes

Appendix G - Progress Update - Maternity Services Improvement Plan

Terms of Reference

Purpose of the Independent Oversight Panel

Provide the oversight¹ which is necessary to enable Cwm Taf Morgannwg University Health Board to implement the recommendations of the Royal Colleges' report in a timely, open and transparent manner.

Terms of Reference

- Establish robust arrangements which provide assurance to stakeholders that the recommendations of the Royal Colleges' review and other associated recommendations are being implemented by the Health Board. Set and agree milestones and deliverables and track progress against them;
- Establish and agree an independent multidisciplinary process to clinically review the 2016-2019 serious incidents identified by the Royal Colleges as requiring further investigation. Conduct a 'look back' exercise to 2010 and ensure that anyone who has justified concerns about their care is provided with the opportunity for it to be reviewed. Ensure that any learning which emerges from these reviews is acted upon by the Health Board and others;
- Advise the Health Board on the actions it needs to take to establish effective engagement arrangements which actively involve patients and staff in the improvement of maternity and neonatal services and rebuild wider public trust and confidence in the Health Board;
- Escalate any wider governance related issues or concerns which emerge to the Health Board and Welsh Government as appropriate.
- Advise the Minister on any further action which the Panel considers necessary to ensure the provision of safe, sustainable, high quality, patient centred maternity and neonatal services. This should include advice about the need for, and timing of, any follow-up independent reviews and the identification of any wider lessons for the NHS in Wales.

¹ *By the term 'oversight' we mean an objectively derived blend of measures (including target setting, monitoring, scrutiny, challenge, reality testing, guidance, encouragement and support) which in combination, provide assurance to stakeholders (including patients, staff and the wider public) that the Health Board is delivering the improvements which it is required to deliver.*

Independent Maternity Services Oversight Panel

Values, Beliefs and Behaviours

The Independent Maternity Services Oversight Panel's terms of reference are underpinned by a set of core values and beliefs which guide the Panel's behaviours and set expectations for the behaviours of others involved in the oversight.

By acting as role models we hope to encourage the kind of behaviours which will provide the fundamental underpinnings of the Health Board's improvement journey.



FOCUSED ON WOMEN AND FAMILIES – our decisions, recommendations and actions will be driven primarily by safety, quality and experience considerations.

VALUING PEOPLE – we believe that a well led, highly motivated and appropriately engaged workforce is a fundamental requirement for the delivery of safe, high quality, patient-centred services.

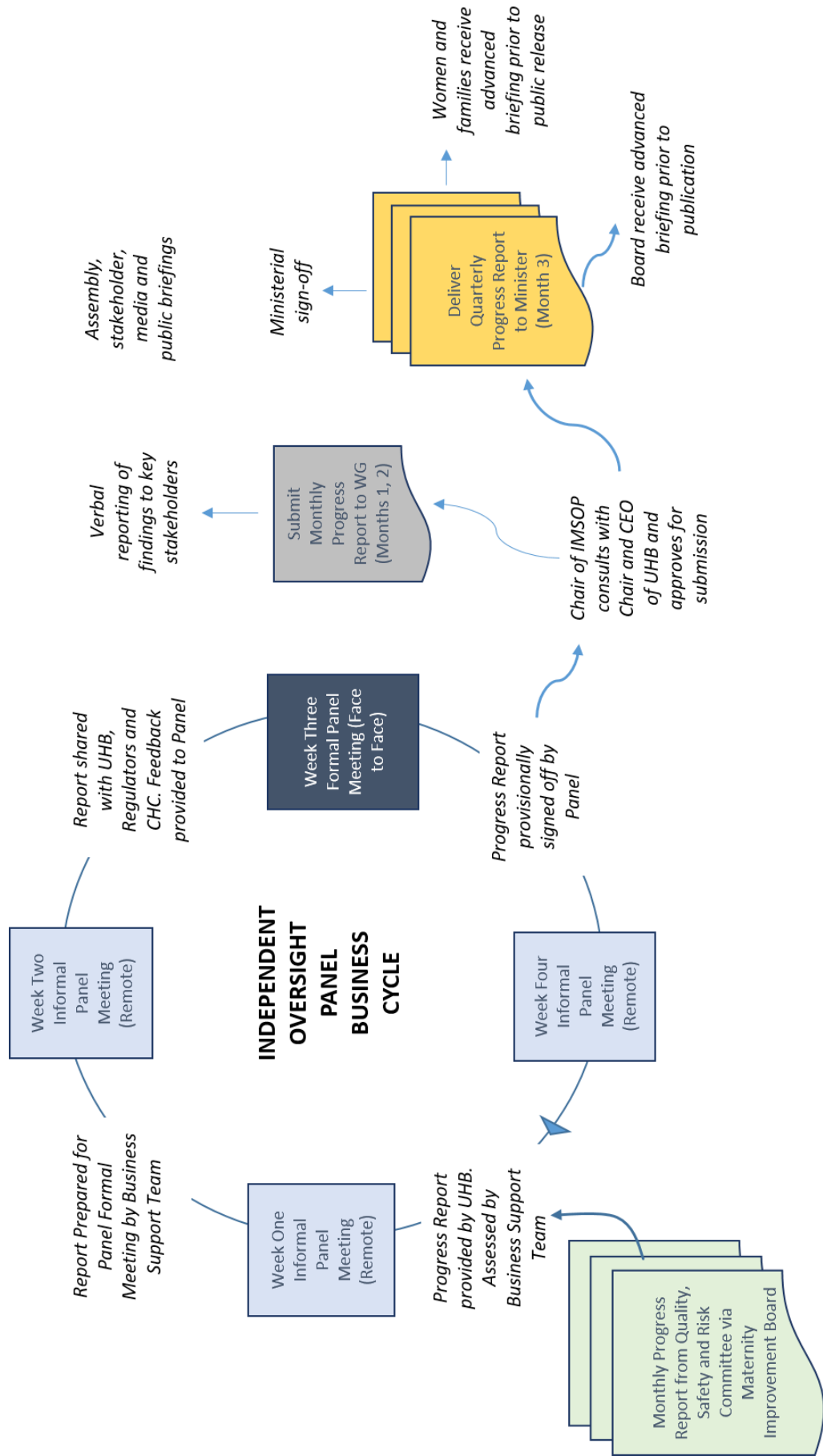
OPEN AND TRANSPARENT - subject to the constraints of patient confidentiality and data protection, we will conduct our work in an open and transparent manner.

INCLUSIVE - we will engage with the women and families affected by service failure, involving them actively in the oversight and improvement process.

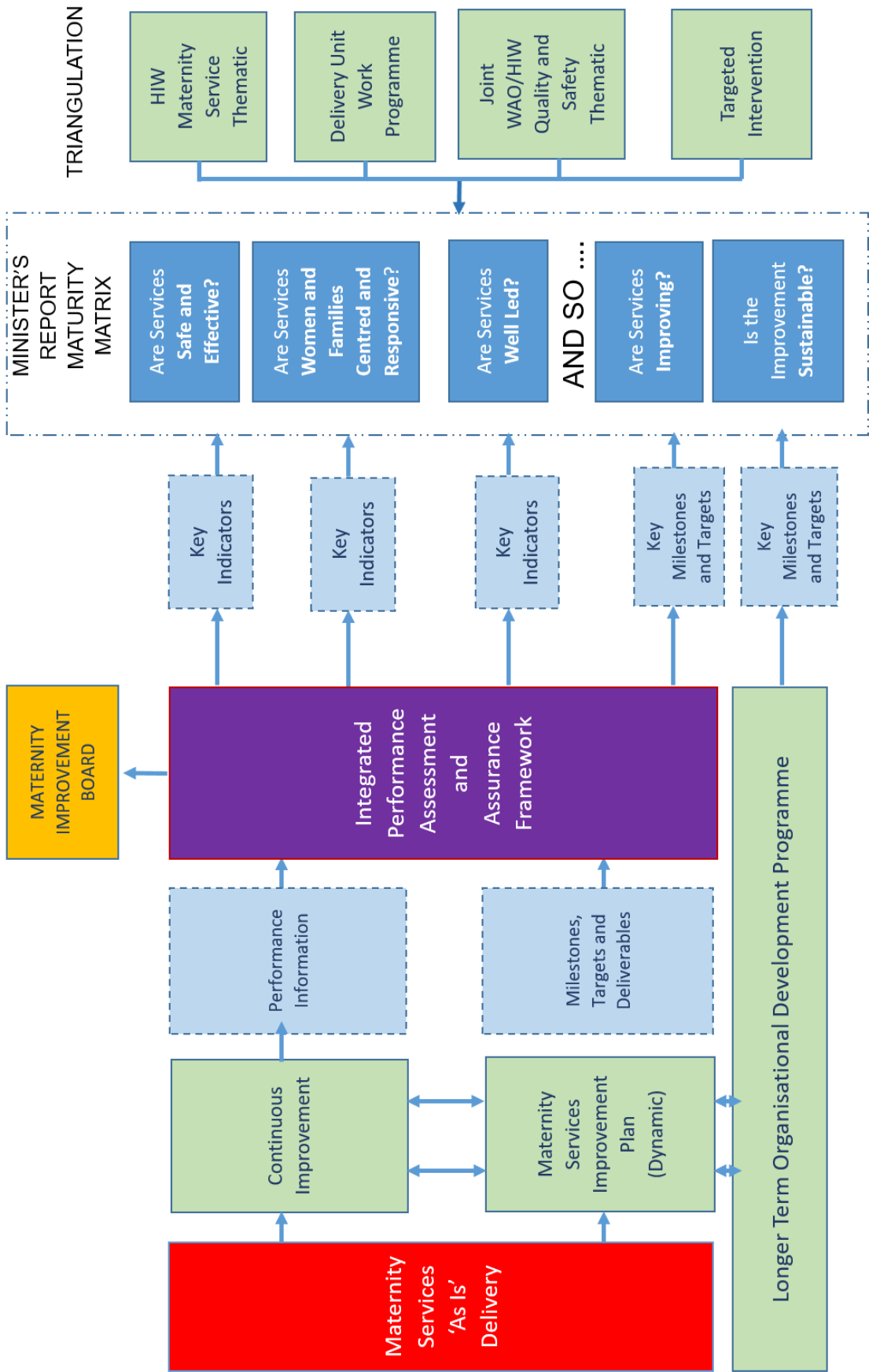
COLLABORATIVE - within an environment of robust scrutiny and challenge, we will work collaboratively with the Health Board to optimise the improvement process and avoid unnecessary bureaucracy, duplication of effort and resource.

Independent Maternity Services Oversight Panel

Monthly Business Cycle



Integrated Performance Assessment and Assurance Framework



Progress Against the Eleven 'Make Safe' Recommendations with the Maternity Services Improvement Plan

Issue identified by RCOG	Summary of Health Board reported evidence and monitoring processes	Health Board assessment
1. The lack of availability of a consultant obstetrician to support the labour ward . Although cover is shown on rota schedules, there is often no actual presence and difficulty in making contact.	<ul style="list-style-type: none"> • Pagers for Consultants • One consolidated Obstetrics Unit • Increased hours of resident labour ward cover (<i>from 40 to 60 hours</i>) • Sample job plan • Datix check (no reported cases of non-availability) • On-site Consultant accommodation 	Addressed
2. There is fragmented consultant cover for the labour ward with frequent handovers , with up to 4 in 24 hours.	<ul style="list-style-type: none"> • One consolidated Obstetrics Unit • Increased hours of resident labour ward cover (<i>from 40 to 60 hours</i>) • Reduced handovers from four to two within 24 hours • Monitoring of handover sheets • Job planning 	Addressed
3. There is inadequate support provided for trainee and middle grade doctors within the obstetric service and particularly on the labour ward.	<ul style="list-style-type: none"> • One consolidated Obstetrics Unit • Increased hours of resident • Dedicated College tutor • Maternity and Obstetric Reflection Meetings • Attendance record and actions • Handover sheets • Monthly training voices • HEIW targeted Deanery reviews 	Addressed
4. The availability of consultants during out of hours cover is	<ul style="list-style-type: none"> • On site consultant accommodation (dedicated Obstetrics and Gynaecology Flat) 	Addressed

unacceptable, with return times of up to 45 minutes.	<ul style="list-style-type: none"> • Consultant availability is being monitored and can be escalated • Datix check (no reported cases non-availability) 	
<p>5. The service has a high usage of locum staff at all grades and specialities. There is no effective induction programme for these staff.</p>	<ul style="list-style-type: none"> • Mandatory Induction Programme in place • Work shadowing period for new locums • Long term locums used for continuity until vacancies filled • Directorate and Locum Induction Programmes and feedback forms • Directorate monitoring • Training group monitoring 	Addressed
<p>6. There was a lack of awareness and accessibility to guidelines, protocols, triggers and escalations. (There was no guidance for common pregnancy complications e.g. pre-eclampsia, which may present to the day unit). This is particularly relevant given point 5 above.</p>	<ul style="list-style-type: none"> • Revised Trigger List (and on MITS System) • Updated guidelines updated, approved and on shared drive • Improvements to Datix Reporting • Datix trend analysis • Governance forums monitoring 	Work in Progress
<p>7. The lack of a functioning governance system does not support safe practice.</p>	<ul style="list-style-type: none"> • New governance structure implemented • Diagram and meeting minutes available 	Addressed
<p>8. The practice of accepting neonates onto the neonatal unit at the Royal Glamorgan site from 28 weeks of gestation is out of line with national guidance and should stop with immediate effect, reverting</p>	<ul style="list-style-type: none"> • British Association of Paediatric Medicine policy is now in place (applied with immediate effect) • Margins of viability criteria • Criteria for attendance at delivery • Consolidated to the one Neonatal Unit at PCH • Datix reporting and 'Badger Net' for babies of less than 32 weeks 	Addressed

to the standard cut off for this level of unit of 32 weeks of gestation.		
9. The high risk obstetric antenatal clinic must be attended and led by a consultant obstetrician with the relevant skills.	<ul style="list-style-type: none"> • Job plans to be changed – job plan for Antenatal Consultant • Single Consultant allocated to clinic 	Addressed
10. The midwifery staffing levels are not compliant with the findings of the Birthrate plus® review in 2017 . The Health Board needs to monitor this in real time at a senior level, to assess if the established escalation protocols need to be invoked to ensure patient safety.	<ul style="list-style-type: none"> • Real time monitoring of midwifery staffing levels (with escalation to board via weekly assurance process) • Continuous recruitment process • Birthrate Plus re-evaluation (results due in October 2019) • Daily acuity monitoring • Datix reporting when below agreed staffing levels 	Work in Progress
11. The culture within the service is still perceived as punitive . Staff require support from senior management at this difficult time.	<ul style="list-style-type: none"> a) Governance structure and purpose redefined b) Staff engagement sessions led by Executive Team c) OD plan to be implemented <ul style="list-style-type: none"> - Wider OD work and staff engagement 	Work in Progress

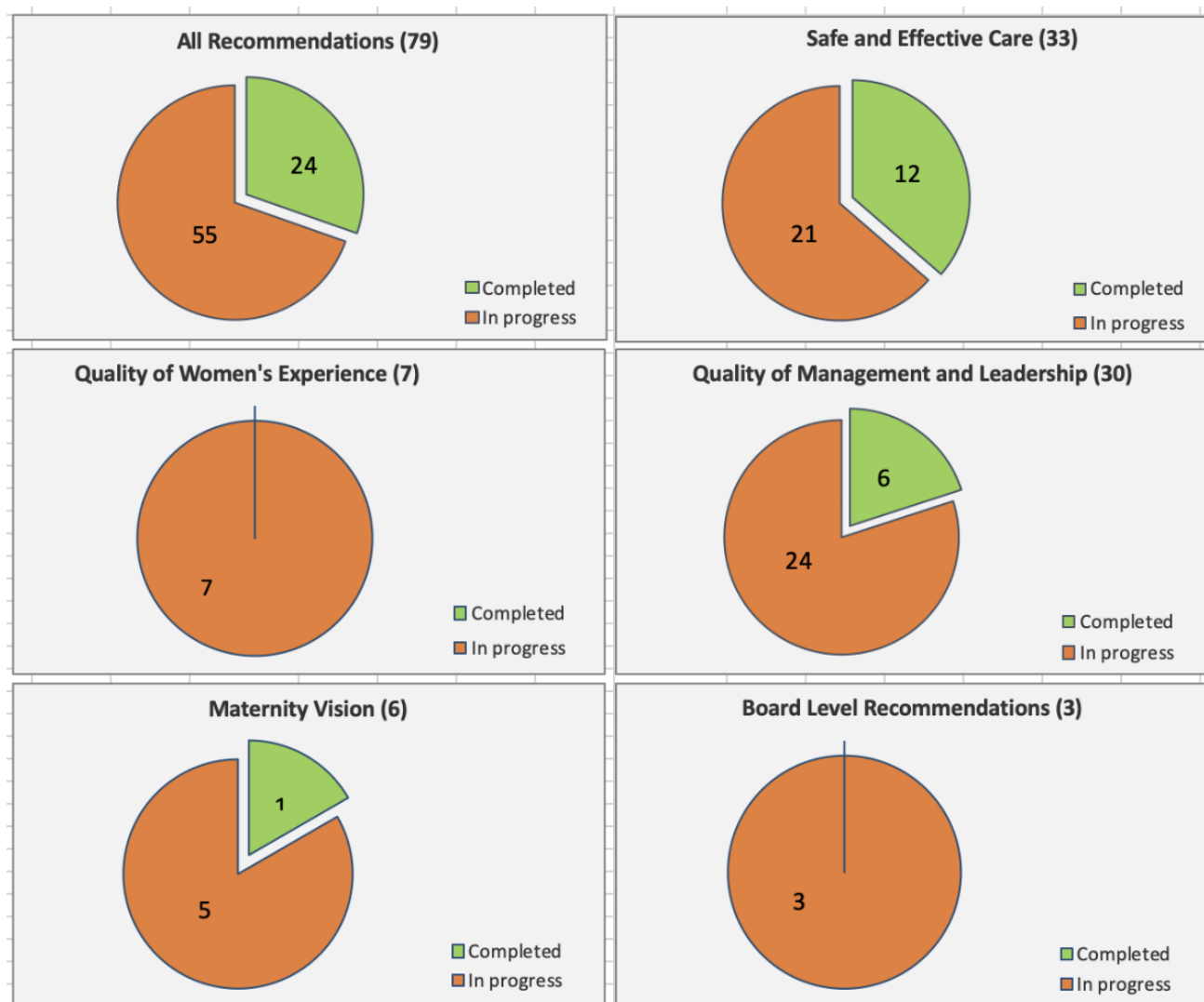
Summary Themes emerging from the 'collaborative check-in' on 17 September 2019

This is based on the three domains of the IPAAF and four key themes from the '15 Steps for Maternity'.

Welcoming & Informative	<p>Staff welcomed the Panel as we entered the Antenatal Unit and introduced themselves. They also welcomed service users as they entered.</p> <p>The panel felt that the Antenatal and Day Assessment Unit was cramped, with narrow corridors and inadequate lighting in some areas.</p> <p>There was signage but this was sub-standard, temporary signage in some areas.</p> <p>Notice Boards were general uncluttered, contained relevant information and were adequately organised. The exception to this was the central notice board on Labour Ward which was not fully up-to-date.</p> <p>There was a topic of the month notice board in the Labour Ward - the current topic was sepsis. There were also PSAG Board and a Greatix Board capturing positive comments.</p> <p>In the Antenatal/Day Unit, there was a general feeling of a lack of privacy with some conversations taking place in corridors.</p>
Safe & Clean	<p>All clinical areas visited appeared to be generally clean including the Day Unit Waiting Area.</p> <p>Confidential paper waste was stored in open paper bags rather than sealed blue bins.</p> <p>The Antenatal/Day Unit waiting area appeared clean, as did the Labour Ward.</p>

Friendly & Personal	<p>Staff were professional and friendly.</p> <p>Staff were open in their discussions with the Panel including around some of the challenges and concerns they had.</p>
Organised & Calm	<p>During the Panel's visit, clinical areas appeared organised and staff seemed to be going about their business in a calm and professional manner.</p> <p>However, there were some comments that things were not always organised and could be chaotic at times.</p>
Staff Comments/ Additional Observations	<p>It was made clear that no attributable comments would be collected. Key themes included some staff feeling that the antenatal clinic was cramped, narrow and lacked privacy for service users to discuss issues at times – in particular the office used when having to break bad news .</p> <p>The antenatal clinic was busy and it was stated that this can be stressful for staff at times.</p> <p>It was commented that things could be chaotic at times especially at times of high demand when there was an overspill into other clinical areas.</p> <p>Staff seemed aware of some of the key challenges from the RCOG review and also on accessing data on the Clinical Dashboard.</p> <p>Whilst several remarks were made about both a punitive culture and a blame culture still being in place - staff appeared willing to discuss this openly.</p>

Maternity Services Improvement Plan **Assessment of Progress as of 20 September 2019**



12 GLOSSARY OF TERMS

AM	Assembly Member
AMU	Alongside midwifery led unit
Badgernet	Neonatal patient data management system
BR+	Birthrate plus
CD	Clinical Director
CEO	Chief Executive Officer
CHC	Community Health Council
CMB	Clinical board meeting
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COO	Chief Operating Officer
CPD	Continual professional development
CSfM	Clinical supervisors for midwives
CSR	Caesarean section rates
CTG	Cardiotocography
CTMUHB	Cwm Taf Morgannwg University Health Board
CTUHB	Cwm Taf University Health Board
Datix	Patient safety software
DON	Director of Nursing
DU	NHS Wales Delivery Unit
EBC	Each Baby Counts
ELCS	Elective caesarean section
EMCS	Emergency caesarean section
Euroking	National maternity IT system
GAP	Growth assessment protocol
Greatix	Initiative based on 'Datix' for reporting positive feedback to staff

GROW	Gestation related optimal weight
HB	Health board
HEIW	Health Education & Improvement Wales
HIE	Hypoxic ischaemic encephalopathy
HIW	Healthcare Inspectorate Wales
HOM	Head of Midwifery
HOMAG	The All Wales Heads of Midwifery Advisory Group
HR	Human resources
HSCSC	Health, Social Care & Sport Committee
HTA	Human Tissue Authority
ICU	Intensive Care Unit
IMSOP	Independent Maternity Services Oversight Panel
IOL	Induction of labour
IPAAF	Integrated Performance Assessment and Assurance Framework
KPI	Key performance indicators
LA	Local Authority
LNU	Local neonatal unit
LSA MO	Local supervising authority midwifery officer
LSCS	Lower segment caesarean section
MBRRACE	Mothers and babies: Reducing risk through audits and confidential enquiries
MDT	Multidisciplinary team
MDT	Multidisciplinary team
MHSS	Minister for Health and Social Services
MIB	Maternity Improvement Board
MID	Maternity Improvement Director
MIP	Maternity Improvement Programme
MITs	Maternity Information Technology System (feeds into QlikSense)

MLC	Midwifery led care
MLU	Midwifery led unit
MPB	Maternity performance board
MSLC	Maternity Services Liaison Committee
MVF	Maternity Voices Forum
NEWTT	Neonatal early warning track and trigger
NICU	Neonatal intensive care unit
NMPA	National Maternity and Perinatal Audit
NNAP	National Neonatal Audit Programme
O&G	Obstetrics and gynaecology
OD	Organisational development
PADR	Personal appraisal and development review
PALS	Patient Advice and Liaison Service
PCH	Prince Charles Hospital
PDM	Practice development midwife
POW	Princess of Wales Hospital
PSAG	Patient status at a glance
PSOW	Public Service Ombudsman for Wales
PTR	Putting Things Right
Q&S	Quality and safety
QA	Quality assurance
QlikSense	Business intelligence and visual analytic software
QSR	Quality, Safety & Risk
RCA	Root cause analysis
RCA	Royal College of Anaesthetists
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics & Child Health

RGH	Royal Glamorgan Hospital
SB	Stillbirth
SBAR	Acronym for stillbirth, background, assessment and response
SCBU	Special care baby unit
SCU	Special care unit
SFH	Symphysis fundal height
SGA	Small for gestational age
SI	Serious incident
SM	Special Measures
SMART	Acronym for Specific, Measurable, Achievable, Relevant and Time-Based
SOM	Supervisor of midwives
SRO	Senior Responsible Officer
SUI	Serious unreported incident
SWP	South Wales Plan
TI	Targeted Intervention
Trac	A large UK database of 'jobs boards' for health and public sector
UHB	University Health Board
USS	Ultrasound scan
WAO	Wales Audit Office
WG	Welsh Government
WRP	Welsh Risk Pool