



INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL

Cwm Taf Morgannwg University Health Board

Quarterly Progress Report
Winter 2020

The Independent Panel was established by Welsh Government in response to the findings of an independent review of maternity services in the former Cwm Taf University Health Board

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 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 which places the women and families affected by the review at the heart of the process.

The Panel is required to report progress to the Minister on a quarterly basis.¹ This report, the second to be published to date, covers the period of October, November and December 2019.

Mick Giannasi (Chair)

Cath Broderick (Lay Member)

Alan Cameron (Obstetric Lead)

Christine Bell (Midwifery Lead)

¹ **ERRATUM** - The Panel has been asked to make it clear that there was an inaccurate statement in its Autumn Quarterly Progress Report which was published on 08 October 2019. This appeared in Section 7.2 (page 21) and indicated that 'positive verbal feedback' had been received from the Nursing and Midwifery Council (NMC) about the training environment for student midwives. Although the reference had some basis in fact, the Panel misinterpreted information which was provided by the Health Board and wrongly attributed the comments to the NMC. It also overstated the process, which could be better described as a progress check meeting, rather than a review. On that basis, the reference has been removed from the original document and the Panel has apologised to the NMC for any inconvenience which was incurred as a result of the error.

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.

TABLE OF CONTENTS

1	Executive Summary	1
1.1	Early Developments	1
1.2	Further Progress Against the Maternity Improvement Plan.....	1
1.3	Other Indications of Improvement	2
1.4	Engagement with Women and Families	3
1.5	Independent Clinical Reviews	4
1.6	Wider Organisational Development.....	4
1.7	Key Issues And Areas For Focus.....	5
1.8	Summary of Conclusions and Next Steps.....	6
2	Purpose and Format of Report	8
3	Background and Context	10
4	Engagement with Women and Families	12
4.1	Planning, Design and Delivery of Engagement and Communication	12
4.2	Community Engagement Events.....	12
4.3	Using the Products of Engagement.....	13
4.4	Building Engagement Opportunities at all Levels	14
4.5	Complaints, Concerns and Support for Families	15
4.6	Involving Women and Families in Panel Communications	16
4.7	Staff Engagement	16
5	Independent Clinical Reviews.....	17
5.1	Clinical Review Project Group.....	17
5.2	Recruitment of Clinical Reviewers.....	17
5.3	Induction Programme for Clinical Reviewers	17
5.4	Clinical Review Groups	18
5.5	Timeframes for Completing the Reviews	19
5.6	Post-October 2018 Incidents.....	19
5.7	Self-Referrals	20
6	Assurance Framework and Maturity Matrix	21
6.1	Utilising the IPAAF – Progress to Date	22
6.2	Development of the IPAAF – Next Steps	24
7	Health Board Response.....	25
7.1	Creating the Foundations for Sustainable Improvement	26

7.2	Maternity Improvement Team - Capacity and Resilience	30
7.3	Wider Health Board Development Plan.....	31
7.4	Joint HIW/WAO Review of Quality Governance Arrangements	32
8	Assessment of Progress Against the Maternity Improvement Plan	33
8.1	Further Progress Against RCOG 'Make-Safe' Actions	33
8.2	Progress Against The Maternity Improvement Plan	35
8.3	Developing the Maternity Improvement Plan.....	36
8.4	Other Sources of Information and Evidence	37
8.5	Overall Assessment of Progress Against the Maternity Improvement Plan	38
9	Conclusions and Next Steps.....	39
9.1	Key Priorities for the Next Quarter	40
9.2	Recommendations	40
10	List of Appendices	41
11	Glossary of Terms	56

1 EXECUTIVE SUMMARY

The Independent Maternity Services Oversight Panel was appointed by the Minister for Health and Social Services 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 which places the women and families affected by the review at the heart of the process.

1.1 EARLY DEVELOPMENTS

In its Autumn Quarterly Progress Report, published in October 2019, the Panel reported that the foundations for improvement were largely in place; effective leadership, appropriate programme management arrangements, clear lines of governance and accountability and a genuine commitment to deliver change at Board and senior leadership levels. There was also evidence that most of the safety critical actions recommended by the Royal Colleges had been addressed. Where those actions were still work in progress, there were reasons for that and systems had been put in place to monitor and mitigate any adverse consequences.

The Health Board was working collaboratively with the Panel and other stakeholders to deliver its Maternity Improvement Plan² within an environment of robust scrutiny and challenge. The Health Board had also recognised that the underlying causes of poor performance extended beyond maternity services and a wider organisational development plan, focusing on leadership development and cultural change, had been designed and was about to be implemented.

Although progress was undoubtedly being made, the Panel reported that there was still a long way to go to create the sustainably safe, high quality, responsive services which the Health Board aspired to provide for its communities and called for an increase in pace, cohesion and administrative discipline in order to achieve that.

The Panel also identified a series of issues which it expected to see progress against by the time it next reported. These issues and a summary of the progress which has been made against them are set out in Section 7 of the report.

1.2 FURTHER PROGRESS AGAINST THE MATERNITY IMPROVEMENT PLAN

Building on those solid foundations, the Health Board has made **good progress** during October, November and December and the Panel is now **cautiously optimistic** that longer-term sustainable improvement in maternity services will be delivered as the programme of work matures.

² The Maternity Improvement Plan is a consolidated action plan which contains 79 actions which address the seventy recommendations emerging from the Royal Colleges' review and nine other recommendations which emerged from associated internal reviews.

There is tangible evidence of further progress against the 79 actions set out in the Maternity Improvement Plan and clear indications, supported by information from a range of internal and external sources that the service is improving more generally.

That improvement can be seen not only in terms of the safety and quality of the care which is now being provided but also in the better experience of the women and families who are using the service and in the way in which the service is being managed, led and governed.

In particular, further progress has been made against the three safety critical recommendations which remained work in progress and the Panel has assessed evidence which provides them with reasonable assurance that a further 25 recommendations have been delivered since they last reported. This includes:-

- improvements in the quality of training for both medical and midwifery staff together with increased rates of compliance and robust plans for future delivery;
- the creation of a comprehensive clinical governance framework with clear evidence that this is now operating and resulting in improvements in clinical practice;
- confirmation that the midwifery and nursing staffing levels which the Health Board has been working to over the past nine months are in line with Birthrate Plus recommended levels;
- the development of a clinical audit process and improvements in the processes for recording, investigating and learning the lessons from serious incidents.

A number of these recommendations will need to be revisited periodically over the next six to twelve months to ensure that they continue to develop and remain embedded in operational practice. The Panel will build this into its programme of assurance visits going forward.

A more detailed assessment of the progress which has been made in delivering against the Maternity Improvement Plan and in particular against the Royal Colleges' recommendations during the last three months is set out in Section 8 of the report.

1.3 OTHER INDICATIONS OF IMPROVEMENT

Whilst the Panel's focus has been on ensuring that there is an evidence base to demonstrate progress against the Maternity Improvement Plan, there has also been other, sometimes more qualitative information, which indicates that services are improving and that this is having a positive impact on the experience of women and families. For example:-

- over the past three months, the twice weekly surveys conducted by the Health Board's Patient Advice and Liaison Service (PALS) have identified consistently high levels of satisfaction from women using the services at Prince Charles Hospital (PCH) and there is evidence of increasingly positive feedback from women and families about the quality and dignity of care provided in the Tirion Birth Centre at Royal Glamorgan Hospital (RGH);

- that more positive feedback from women and families is corroborated to a significant degree by a report which was recently published by the Cwm Taf Morgannwg Community Health Council (CHC) following unannounced visits to Prince Charles and Royal Glamorgan Hospitals during June, July and September 2019;
- recent reports from Health Education and Improvement Wales (HEIW) have highlighted incremental improvements in the training and education environment for medical staff working in the obstetrics team, albeit that there are still some areas which require further attention.

Perhaps the most significant indicator of progress to date is provided by Healthcare Inspectorate Wales (HIW) which published its report into an unannounced three-day inspection of the Tirion Birth Centre at RGH in September. This report, which was published on 13 December 2019, concludes overall that *'care was provided in a safe and effective manner'* whilst *'staff demonstrated a clear passion and drive to provide high standards of care to patients, in a homely, relaxed environment'*. There were a small number of areas for improvement, but these did not indicate fundamental weaknesses within the service.

The Health Board is currently awaiting the publication of an unannounced inspection of the consultant led-service provided at PCH which was conducted in November 2019. This is expected to be published shortly and will provide the most significant external assessment yet of the progress which has been made.

A more detailed analysis of the indicators of improved performance is outlined in Section 8 of the report.

1.4 ENGAGEMENT WITH WOMEN AND FAMILIES

Good progress has also been made in improving the way in which the Health Board engages with women and families and involves them and the wider community in helping to design and improve maternity services.

With the support of the Panel and the contribution of an external specialist, the first two Engagement Events have been held and a great deal has been learned from the process. The events have generally been well-received by the women and families who have attended and also by the staff members that have participated. The third Engagement Event is scheduled to take place in Bridgend in February 2020 after which the learning from the process will be evaluated and an action plan developed to ensure that the key themes and issues are addressed and that the views of those who have and continue to use the service are reflected in practice.

The learning which has been derived from the first two events is enabling the Health Board to review the way in which it engages with service users and communities more broadly. This will help to improve the effectiveness of the corporate engagement and communication strategy which is currently being developed.

A more detailed summary of the progress which has been made in this area is outlined in Section 4 of the report.

1.5 INDEPENDENT CLINICAL REVIEWS

Progress has also been made in terms of implementing the first phase of the clinical review programme; this will independently consider the care provided to around 140 women and babies between January 2016 and October 2018 that falls within the agreed criteria.

The multidisciplinary teams of midwives, obstetricians, anaesthetists and neonatologists who will be conducting the reviews have been recruited and inducted. A pilot study has been undertaken in order to 'test' the systems which have been put in place and to ensure consistency of approach. The women whose care is being reviewed have been informed and have been invited to participate in the process if they wish to do so.

A more detailed summary of the progress which has been made in implementing the clinical review strategy is outlined in Section 5 of the report.

1.6 WIDER ORGANISATIONAL DEVELOPMENT

At an early stage in the process, it was recognised that the underlying causes of the failings which were identified by the Royal Colleges were unlikely to be confined to maternity services. As a result, the Board has designed and begun to implement a wider organisational development programme which, amongst other issues, is designed to improve leadership and governance at all levels and to redefine the culture and values of the organisation. This work is both informed by and complementary to the maternity services improvement work which the Panel is overseeing and it has worked closely with the interim Chief Executive and her team to ensure that the programmes of work are aligned.

In particular, the Panel is working with the Health Board to ensure that the action plan which has been developed in response to the Review of Quality Governance Arrangements which was conducted jointly by the Wales Audit Office (WAO) and Healthcare Inspectorate Wales (HIW) is closely aligned with the Maternity Improvement Plan, given that many of the issues are cross-cutting.

A summary of how the wider organisational development work is helping to support maternity services improvement is set out in Section 8 of the report.

1.7 KEY ISSUES AND AREAS FOR FOCUS

Despite the obvious signs of progress identified in this report, there is still a great deal of work to be done to deliver against all of the recommendations from the Royal Colleges' review and the other associated recommendations and more so, to ensure that the improvements which have been delivered so far are embedded in practice and sustainable in the longer term.

More than two-thirds (68%) of the actions in the Maternity Improvement Plan are still work in progress and many of those will require changes in culture and operational practice to fully deliver them; this is something which experience elsewhere shows will not be delivered overnight.

Behaviours are changing and the majority of staff at all levels have responded positively and enthusiastically to the challenges which the Royal Colleges highlighted; this is evident in the feedback from internal and external reviews and from the Panel's own observations whilst visiting the hospitals and talking to staff. However, there is still some way to go to bring about the real change in attitudes and beliefs which is needed to deliver long term sustainable improvement.

It is also important to recognise that the ultimate objective is to improve outcomes for women and families and that in important areas, such as rates of caesarean sections and rates of inductions of labour, there is still significant work to do in order to meet the performance standards achieved in other Health Boards. That said, there is evidence of some innovation within the Health Board to address these issues and multidisciplinary working groups have been established to identify opportunities for improvement.

Similarly, although incremental progress is undoubtedly being made, there is still a need for more pace and better administrative discipline in the way that the change process is being managed by the Health Board. In particular, there has not been as much progress as the Panel hoped to see in terms of developing the Integrated Performance Assessment and Assurance Framework (IPAAF) which will enable longer-term improvement in outcomes to be monitored and assessed.

There is also work still to be done to develop the Maternity Improvement Plan into a more dynamic and responsive plan with clear milestones, targets and deliverables. Equally, although the foundations are now in place and delivery plans have been developed, there is still a long way to go to improve critical business systems and process like those for handling complaints and concerns and for capturing and responding to feedback from service users.

The handling of complaints and concerns remains a matter of concern. Progress is being made, particularly in responding within more appropriate timescales to new referrals, but there are still significant challenges in terms of addressing the backlog of historical complaints. The current arrangements are not as coordinated as they need to be and the culture is still sometimes defensive with promises and deadlines sometimes not being kept. The Health Board has a clear plan to address these issues but it will need to be delivered quickly and effectively if it is going to regain the trust and confidence of the women and families affected by the failings identified by the Royal Colleges.

In addition, there have been consequences of gaps in capacity and capability within the Improvement Team. For example, it was necessary to defer the implementation of the clinical review programme by a month because the Panel was not confident that the Health Board had the necessary arrangements in place to support the process and in particular to ensure that the needs of women and families could be met.

There have been a number of factors which have hindered the pace of progress, not least some unexpected and unavoidable absences in critical positions within the Maternity Improvement Team and externally driven delays in recruiting to key posts.

There have also been changes in circumstances, for instance an expansion of the scope and scale of the clinical review programme which has created additional resourcing implications and increased workloads. An example of this are the requirements for anonymising clinical records.

At the beginning of December, the Panel was becoming increasingly concerned that there was insufficient capacity and resilience within the maternity improvement function to deliver the improvement plan *and* support the clinical review programme *and* manage engagement and communication with women and families. In addition, the Panel remained concerned that there were gaps in capability in critical areas like performance analysis, quality improvement and patient engagement which in some cases are being filled by clinical staff who are highly motivated, committed and building significant experience but do not necessarily have all of the specialist skills required to undertake the role at this stage.

These issues have been raised with the Health Board and there has been a positive response. Some additional capacity and greater flexibility have been identified and a restructuring of the Maternity Improvement Team will take place early in the New Year. This provides the Panel with increased confidence that the process will move forward with further pace and additional administrative discipline in the next quarter.

There has also been some reciprocal feedback for the Panel about clarity of expectations and consistency of approach which has also been taken on board.

A more detailed analysis of these issues is summarised within Section 8 of the report.

1.8 SUMMARY OF CONCLUSIONS AND NEXT STEPS

Whilst there still remains much to be done to deliver against the Royal Colleges' recommendations, the Health Board has made good progress during the last quarter and the Panel is now cautiously optimistic that longer-term sustainable improvement in maternity services will be delivered in due course.

However, there is a need for increased pace and administrative discipline in the way that the Health Board is managing the improvement process and constructive discussions have taken place to agree a revised structure and an increase in capacity which will address that.

The priorities which have been agreed for the next three months include:-

- further work to develop the IPAAF with more sophisticated metrics, clearer priorities and stretching but achievable improvement targets over time;
- a concerted focus to develop those elements of the Maternity Improvement Plan which remain to be delivered into a more dynamic and constantly evolving document with clearer actions, milestones for delivery and measurable outcomes;
- further delivery against the remaining 54 recommendations within the Plan and a focus on embedding those recommendations which have already been delivered into operational practice;
- progressing the clinical review programme to the implementation stage with a specific focus on supporting the women and families involved;
- completing the engagement events with women and families, assessing the outcomes and developing a plan to reflect the lessons learned in operational delivery.

In view of the progress which is being made and the ongoing commitment which the Health Board has shown to the improvement process, the Panel does not feel that it is necessary to make any specific recommendations at this stage.

2 PURPOSE AND FORMAT OF REPORT

The purpose of this report is to summarise the progress which the Independent Maternity Services Oversight Panel is making in discharging the terms of reference set by the Minister for Health and Social Services.

In particular, the report provides an ongoing assessment of the progress which the Health Board is making in delivering the improvements in maternity services which were identified as necessary by the Royal Colleges and other associated reviews, as well as providing assessments of progress against the clinical review and engagement aspects of the Panel's responsibilities.

This is the Panel's second quarterly report which reflects developments and events which have occurred during October, November and December 2019. It builds upon the previous quarterly report which was published in October 2019. In the interests of brevity, background information contained within the first report is not repeated.

In addition to highlighting those areas where progress has been made, the report also identifies the key issues and challenges which are constraining 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 designed to be a public facing document. As far as is possible in a document of this nature, it is written in simple language which minimises the use of technical terms and detailed performance information. 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.

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 report than the Panel would have liked. The intention is that subsequent reports will be more evidence based and more focused on outcomes as the Integrated Performance Assessment and Assurance Framework which has been agreed with the Health Board (see Section 6 below) begins to mature.

The report is broken down into discrete sections as follows:-

- **Section 3 (Background and Context)** summarises the background to the Minister's decision to place maternity services in special measures and explains very briefly how the Panel has been established to discharge its terms of reference. This section is intentionally brief, having been covered in some detail in the Panel's first quarterly report;
- **Section 4 (Engagement with Women and Families)** provides an assessment of the progress which has been made by the Health Board as it continues to build its capability and capacity to engage with women and families who use maternity services;
- **Section 5 (Independent Clinical Reviews)** explains the progress which has been made in the last three months in progressing the Clinical Review Strategy which was published alongside the firstly quarterly report in October 2019;
- **Section 6 (Assurance Framework and Maturity Matrix)** outlines the progress which has been made in developing the Integrated Performance Assessment and Assurance Framework (IPAAF) which has been agreed between the Health Board and the Panel as the basis for assessing progress and current assurance levels. It also explains how the IPAAF underpins the Maternity Services Improvement Maturity Matrix;
- **Section 7 (Health Board Response)** provides an assessment of the arrangements that the Health Board has put in place in response to the Minister's intervention and highlights areas where further development is necessary in order to optimise the potential for improvement;
- **Section 8 (Assessment of Progress against the Maternity Improvement Plan)** provides the Panel's assessment of the progress which has been made to date in delivering against the 79 actions contained within Maternity Improvement Plan (MIP);
- **Section 9 (Conclusions and Next Steps)** sets out the Panel's overall assessment and identifies what the Minister might expect in terms of delivery during January, February and March 2020.

In view of the progress which is being made and the ongoing commitment which the Health Board has shown to the improvement process, the Panel does not feel that it is necessary to make any further specific recommendations in this report. The Health Board is currently managing a significant number of action plans and the Panel does not wish to add to the administrative burden.

However, there are a number of areas where further action is required in the next quarterly reporting period in order to sustain and build upon the progress which has been made; these 'next steps actions' are highlighted within the report and will be picked up in collaboration with the Health Board through the Panel's regular business cycle.

3 BACKGROUND AND CONTEXT

This section of the report provides a very brief summary of the background to the Minister's intervention and a short explanation of the role of the Independent Maternity Services Oversight Panel.

It has been kept deliberately brief because the background was explained in some detail in the Panel's Autumn Quarterly Report which was published in October 2019. The report can be accessed [here](#). However, the background can be summarised as follows.

In October 2018, as a result of growing concerns about the quality and safety of care being provided in the maternity units at the Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH), the Welsh Government commissioned an independent review by the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM).

The Royal Colleges' report, setting out the findings of their review, was published on 30 April 2019 and highlighted serious concerns about quality and safety, compounded by failings in corporate governance, dysfunctional relationships and inappropriate culture and behaviours. A supplementary report which captured the stories of some of the women and families who had used the service painted a distressing picture of patient experience and service quality that was far short of an acceptable standard.

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

As a result of the Royal Colleges' findings and as part of a broader package of interventions, the Minister placed maternity services within the former Cwm Taf University Health Board in special measures.

A more detailed explanation of the background to the Royal Colleges' review and the Minister's intervention can be found in Section 3 of the Panel's Autumn Quarterly Report.

At the same time, the Minister appointed the Independent Maternity Services Oversight Panel to seek robust assurance from the Health Board that the recommendations within the Royal Colleges' report were being implemented in a timely, open and transparent way which placed women and families affected by the review at the heart of the process.

A copy of the terms of reference for the Panel can be found at '*Appendix A*'.

The Panel has developed a collaborative relationship with the Health Board from the outset in order to minimise any unnecessary bureaucracy and duplication of effort whilst maintaining an environment of robust challenge and scrutiny.

The Panel's business cycle is now well established based around a formal monthly Panel meeting attended by a range of stakeholders who have the status of participating observers. This includes representation from the Community Health Council and the Trade Unions. Other agencies include the NHS Delivery Unit, Healthcare Inspectorate Wales and the Wales Audit Office.

Further information about the Panel, its terms of reference and operating methodology can be found in Section 4 of the Panel's Autumn Quarterly Report.

The Health Board has responded positively and constructively to the Minister's intervention and has put a framework in place to deliver the improvements in maternity services which are necessary. This includes the appointment of a Senior Responsible Officer at Board level, the establishment of a Maternity Improvement Board reporting directly to the Board via its Quality and Safety Committee (formerly the Quality, Safety and Risk Committee) and the creation of a dedicated Maternity Improvement Team which is managing the delivery of the MIP, supported by three project groups.

At the same time, the Health Board has also recognised that some of the underpinning challenges and issues identified by the Royal Colleges are broader than maternity services and has established an organisation wide development programme to redefine the organisation's vision and values and to improve leadership and engagement at all levels from Board to operational level.

Further information about the way in which the Health Board has organised itself in order to respond to the Royal Colleges' review can be found in Section 8 of the Panel's Autumn Quarterly Report.

4 ENGAGEMENT WITH WOMEN AND FAMILIES

The Panel's Lay Member was part of the Royal Colleges' team which conducted the review and was the author of the '*Listening to Women and Families*' supplementary report. This has enabled her to build and maintain a strong bond with some of the women and families who have been affected by the review.

She has also built constructive working relationships with the key members of staff in the Health Board (most notably the Maternity Improvement Director and the Consultant Midwife) and this has enabled early progress to be made in the area of engagement and communications. Importantly, having played a pivotal role in leading and co-ordinating action in the initial stages, the Lay Member is now increasingly stepping back to enable the Health Board to take ownership for the leadership and strategic direction of the engagement and communication element of the MIP.

The key developments which have taken place during October, November and December 2019, together with an assessment of what further remains to be done in terms of engagement and communication are set out in the following paragraphs.

4.1 PLANNING, DESIGN AND DELIVERY OF ENGAGEMENT AND COMMUNICATION

The Women and Families Engagement Project Group is now well established and is leading maternity services engagement and communications activities with women and families. The group has a multidisciplinary membership including obstetricians, midwives, patient and public engagement leads as well as women and families.

There are significant benefits from collaborative engagement; the group has worked together to ensure that the community engagement events which lie at the heart of the approach have created the opportunity to share information, build relationships and receive feedback about people's experiences. The planning process has also produced valuable learning about the methodology used to facilitate such events which is influencing the development of the Health Board's wider approach.

4.2 COMMUNITY ENGAGEMENT EVENTS

The first of the three community engagement events which are planned took place on 08 November in Merthyr Tydfil, followed by a second event on 28 November 2019 in Llantrisant. Learning from the first event was used to shape the second. In turn, this will influence the third event which is planned for 25 February 2020 in Bridgend.

These events are a visible demonstration of the Health Board's commitment to become a more open, transparent and engaging organisation. The November events were widely acknowledged as a success, with a significant number of women, babies and family members attending.

These events provided valuable opportunities for a two-way exchange of information about the changes the organisation is making in response to the Royal Colleges' Report.

The atmosphere in both events was relaxed and conversation was encouraged resulting in a range of personal experiences and stories being shared. This personal approach, welcoming atmosphere and supportive environment has resulted in positive feedback and staff gained as much from the process as the women and families who attended. The events also had the advantage of building skills and experience amongst staff in how to communicate with people who have lost trust and confidence in the Health Board.

Key to the events was an engaging visual mapping technique that produces a vibrant thematic representation of the priorities and messages heard from women and families attending. The visual methodology is powerful and interactive as people see their words turned into images immediately. The visual map from the first event in Merthyr is shown below with a larger version at 'Appendix B'.

Figure 1: The Visual Map: Improving Maternity Together – Merthyr Tydfil



4.3 USING THE PRODUCTS OF ENGAGEMENT

Early public feedback about the products of the first two engagement events has been provided using the visual maps and photographs on social media, via the 'Bump Talk' chat group, through the 'My Maternity, My Way' forum and on the Health Board's internet page.

At this stage, the two main themes which have emerged relate to post-natal care and support for 'Mums wishing to breast feed' and action plans are being developed in response. Following the third engagement event in February 2020, the Health Board plans to produce a comprehensive report identifying key themes and learning to date. An engagement plan for the remainder of 2020 will also be published. This will ultimately influence the development of 'Maternity Vision', the organisation's emerging longer-term strategy for maternity services.

(NEXT STEPS 1: The Panel looks forward to seeing the outcomes of the thematic analysis from the three Engagement Events and the action plans and further engagement strategy which emerge from it).

Clearly it is beneficial for the staff involved, including midwives, to undertake the thematic analysis themselves in order to build their understanding of women and families' priorities for maternity care. In December, the Panel's Engagement Lead in worked with the Health Board team leading the engagement with women and families in a development session on thematic analysis and how to manage the process.

4.4 BUILDING ENGAGEMENT OPPORTUNITIES AT ALL LEVELS

Building on the lessons learned from the community engagement events, the Project Group has now started to explore other mechanisms for capturing and responding to women's stories. This includes:-

- developing the opportunity to expand the Patient Advice and Liaison Service (PALS) real time feedback initiative to capture women's experiences at the antenatal stage. This will enable the Health Board to identify and resolve issues or concerns at source and allay emerging fears about giving birth;
- exploring ways to capture and analyse social media feedback in a systematic way. There is a significant amount of feedback and discussion on maternity care on social media and 'Bump Talk' in particular provides an active and rich source of insight around women's priorities and concerns;
- further developing the 'My Maternity, My Way' (formerly the MSLC). The skilled and energetic leadership demonstrated by the recently appointed Lay Chair is making a real difference in reaching out to service users. Improved contact with women and families and different approaches to engagement demonstrate that the group has real potential to become a hub for involvement and engagement with women and families;
- procuring a widely used and standardised tool for gaining meaningful and organised feedback on experience of maternity care. This follows a review of the mechanisms which are currently used to capture the experience of women which are deemed to be ineffective and poorly utilised.

(NEXT STEPS 2. The Panel looks forward to seeing these opportunities for further developing the Health Board's capacity to capture and respond to women's experience during the next quarter and in particular to seeing the procurement and launch of the new tool).

The Panel has previously highlighted concerns which have emerged from the maternity services engagement work, regarding capacity and capability to develop the patient and public engagement strategy and systems across the organisation. It is understood that further capacity for patient and public engagement experience is being considered to strengthen the development of the programme.

(NEXT STEPS 3. During the next quarter, the Panel will work with the Health Board to ensure that the lessons emerging from the maternity services engagement work are assimilated at corporate level and, in particular, to ensure that the benefits of engaging specialists rather than adding additional responsibilities to the roles of clinicians are properly understood).

4.5 COMPLAINTS, CONCERNS AND SUPPORT FOR FAMILIES

During engagement and communication events and through direct contact, women and families have regularly expressed dissatisfaction with the response they have received to complaints, concerns and long-term investigations. The current arrangements are not as co-ordinated as they need to be and the culture is still sometimes defensive with promises and deadlines often not being kept.

The handling of complaints and concerns has also been identified as a critical area for development in the systems analysis work which has been undertaken by the NHS Delivery Unit and more recently by the joint HIW/WAO thematic review of quality governance arrangements within the Health Board.

The Health Board has developed a plan to address these issues at organisational level and additional capacity has been identified, in particular, to manage the backlog of historical complaints within maternity services. The plan is currently going through the Health Board's internal approval process and as such, is not yet available to be reported on in the current period. However, the Panel believes that it is an appropriate response to the issue and will focus on how it is being delivered in subsequent quarterly reports.

Work on the plan has already begun and progress is undoubtedly being made, particularly in terms of responding within more appropriate timescales to new referrals. Restructuring work is also taking place so that in appropriate cases, staff are enabled to respond to concerns at a directorate level rather than awaiting corporate approval which builds in delay. However, there are still significant challenges in terms of addressing the backlog of historical complaints.

As such, the plan will need to be delivered quickly and effectively if it is going to regain the trust and confidence of the women and families.

(NEXT STEPS 4: Once approved, the Panel will expect the Complaints and Concerns Improvement Plan to be a feature of its monthly improvement monitoring process and will want to see relevant performance metrics included within the next stages of the development of the IPAAF).

4.6 INVOLVING WOMEN AND FAMILIES IN PANEL COMMUNICATIONS

Following the publication of the first quarterly report, the Panel established its own Engagement Task and Finish Group to explore how best to communicate with women and families about the Panel's work and in particular, how the Health Board is changing in response to the Royal College's review.

A number of family representatives have joined the group and their views have been invaluable in evolving new approaches which are better tailored to the needs of individuals.

4.7 STAFF ENGAGEMENT

During October, November and December, the Panel has increased the level of engagement with staff as part of its monthly assurance visits to maternity units across the Health Board area. Although it is difficult to get staff together in large numbers due to operational commitments, the Panel has engaged in meaningful discussions with staff at all levels, from medical, midwifery and other backgrounds and across all three of the hospital sites.

The staff that the Panel has met, both in focus groups and in workplace settings have been overwhelmingly positive. Staff are clearly working hard under significant pressure and in the main appear passionate about their work. Most comment positively on the changes which have taken place in their working environment since the Royal Colleges' report was published, particularly in terms of their personal development and the quality of education and training they were receiving and wanted to make sure that this is reflected in the Panel's reports. There is also acknowledgement that there is still a long way to go and that not everyone yet is ready to be part of the solution.

Some of the group sessions reflected the negative impact on staff morale which the Royal Colleges' review has generated and they wanted to convey the significant hard work they are undertaking to ensure that change and improvement happens for the benefit of women and families.

Staff engagement is an important means of triangulating the evidence which the Health Board is providing and the Panel will maintain its focus on meeting staff periodically during the next quarter.

5 INDEPENDENT CLINICAL REVIEWS

The Panel's Clinical Review Strategy was published alongside the Autumn Quarterly Report in October 2019 and can be accessed [here](#) if further background information is required.

Section 5 of the Autumn Quarterly Report set out the progress which had been made in developing the Strategy by the end of September 2019.

This section of the report focuses on further developments which have taken place during October, November and December 2019. It also covers planned events which will take place in early January and will have been put into effect by the time this report is published.

5.1 CLINICAL REVIEW PROJECT GROUP

A Clinical Review Project group was set up following publication of the Clinical Review Strategy in October 2019. The project group membership includes the Panel's Obstetric and Midwifery Leads as well as representatives from the Welsh Government, the NHS Wales Delivery Unit and the Community Health Council. This has resulted in the establishment of a secure file sharing portal and underpinning databases. This will allow for remote working of the review teams and it is anticipated that this will provide the most efficient methodology.

5.2 RECRUITMENT OF CLINICAL REVIEWERS

A job specification for obstetric, midwifery, anaesthetic and neonatal clinical reviewers has been produced and circulated through the appropriate clinical networks for submissions of expressions of interest.

All applications were reviewed by the Panel's Obstetric and Midwifery Leads to make certain that all the selected reviewers have the necessary background and experience to undertake the clinical reviews. The Panel have been successful in recruiting, five obstetricians, eight midwives, three anaesthetists and three neonatologists, all independent of Cwm Taf University Health Board.

5.3 INDUCTION PROGRAMME FOR CLINICAL REVIEWERS

Three induction programmes for the Clinical Reviewers have taken place in November and December led by IMSOP clinicians and supported by the Welsh Government and the NHS Delivery Unit. The aim of the induction programme was to ensure that the reviewers were fully aware of the background to the review and understood their role in undertaking the review process. The remainder of inductions will be completed during early 2020.

5.4 CLINICAL REVIEW GROUPS

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

1. The 01 January 2016 – 30 September 2018 cases identified in advance of the Royal Colleges' review (previously referred to as the 43);
2. The 01 January 2016 – 30 September 2018 cases subsequently identified using an agreed inclusion criterion identified by the Panel;
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 their families who have self-referred whose care will be reviewed regardless of whether or not they fit the inclusion criteria.

The first cases which will be reviewed are those in groups one and two. This comprises of around 140³ cases which includes the original 43 cases identified in the Royal Colleges' review.

For the purpose of allocating the Clinical Review Teams, the cases have been sub-divided into three categories as follows:-

Table 1: The Clinical Review Categories

CATEGORIES	DESCRIPTION
1. Maternal mortality and morbidity	Care of mothers, including those who may have needed admissions to intensive care.
2. Neonatal mortality and morbidity	Babies who sadly died following birth or needed specialist care.
3. Stillbirths	Babies who sadly were stillborn.

The Clinical Review Teams commenced their work during December 2019 by undertaking a pilot exercise involving a small number of test cases. This pilot exercise was designed to enable the Clinical Review Teams to quality assure the clinical review process and ensure that it is robust and effective prior to full roll-out to all cases early in the New Year.

The first cases to be reviewed will be those involving mothers who had complications before, during or after pregnancy, including admissions to ICU.

The Panel has written to all of the women whose care is being reviewed to invite them to participate in their individual reviews should they wish to do so.

³ It will be noted that the number of cases being reviewed is slightly lower than the number (circa 150) originally identified in the Autumn Quarterly Report. This is due to more accurate information increasingly being available which has resulted in a number of duplicates being identified. It is important to note that this figure may change as the clinical review work evolves and further information becomes available.

All women and their families will be offered the opportunity to tell their stories and put questions in writing to the Clinical Review Team reviewing their care if they wish to do so. Support will be available from the Community Health Council's Advocacy Service for those women whose care is being reviewed. Women and families will be offered other appropriate support should they require it.

5.5 TIMEFRAMES FOR COMPLETING THE REVIEWS

As this is a new process it is not possible at this stage to make any predictions on how long the review process will take. It is important that the review process is fit for purpose and is robust to ensure that lessons are learnt to improve the safety, quality and responsiveness of the maternity service.

5.6 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.

A review of a small number of cases was undertaken on 16 September and demonstrated evidence of multidisciplinary involvement and good engagement with families. However, the scope of the preliminary assessment was limited due to the number of outstanding cases.

A further review of the most recently completed serious incidents was undertaken on 09 December 2019. There have been 20 serious incidents reported and the Panel has now considered 11 of these which were ready for review. The Panel noted that issues identified in the earlier quality assurance process had been taken back to the service for discussion and changes have been made to subsequent reports.

Whilst a small number of recommendations have been made to the Health Board on areas where improvements can be made, overall, the Panel were impressed by the quality of the majority of the most recent reports.

However, the following recommendations have been made to the clinical risk management team:-

- action plans needed to be SMART as some of the reports lacked measurable objectives;
- minutes/action log should be taken as an output from multidisciplinary team discussions undertaken as part of the review process to demonstrate evidence that such discussions took place;
- a brief outline of staffing levels, patient acuity and capacity of unit is beneficial in setting the scene and understanding any contributory factors.

(NEXT STEPS 5: A further review of the remaining serious incidents that have not yet been reviewed will be scheduled during the next quarter with a view, if that is appropriate, to validating and signing off the current serious incident review process as 'fit for purpose'. Attention will be paid to ensure that the recommendations arising from the previous review have been addressed).

5.7 SELF-REFERRALS

It is apparent that while all of the self-referral cases will need to be reviewed, not all of them will necessitate a full clinical review, depending on the nature of the concern raised. Regardless of whether the cases are suitable for clinical review or not, the Panel will continue to monitor each individual case to ensure that where possible, a satisfactory resolution is achieved which addresses the needs of the women and their families.

The Health Board was asked to propose a way forward for each individual case by 16 December 2019. However, the process which was presented was not deemed suitable for signing off and some further development work is required. That includes providing absolute clarity about which incidents will be classified as self-referrals and how that information is cross referenced with other elements of the clinical review process. This means that the precise number of self-referrals has not yet been accurately identified.

The Health Board has committed to undertake this work as a matter of priority and in any case prior to the Panel's next meeting with women and families in mid-January.

Once the process is signed off, a triaging process will be conducted to identify the most appropriate resolution for each referral. At that stage, contact will be made with the women and families involved to discuss and agree the way forward.

(NEXT STEPS 6: The Panel will work with the Health Board to develop an agreed self-referral process by 16 January 2020 in order that information can be provided to the women and families involved about the review process and the likely timescales for the review being completed).

6 ASSURANCE FRAMEWORK AND MATURITY MATRIX

In its Autumn Quarterly report, the Panel set out its intention to utilise an evidence based Integrated Performance Assessment and Assurance Framework (IPAAF) as the basis of future reporting to the Minister. The framework will also, in the near future, provide the basis of the Health Board's internal performance management and improvement monitoring arrangements through the Maternity Improvement Board to the Health Board's Quality and Safety Committee.

The IPAAF framework is outlined in schematic form at '*Appendix C*'.

A detailed explanation of how the IPAAF was developed, what its purpose is and how it will be ultimately be used to provide assurance is provided in Section 6 of the Autumn Quarterly report. As such, it is not proposed to repeat that information in any detail here. However, a brief explanation may be helpful.

In summary, the framework will utilise a five-level maturity matrix to demonstrate the extent to which the Health Board is making progress against its improvement plans and to what extent that is resulting in improved outcomes for women and families. Progress against the maturity matrix will be measured and assessed in three key domains (safe and effective care, quality of women's experience, well managed and well led) and a judgement framework will be utilised to determine whether services are improving and if so whether that improvement is sustainable.

Each of the domains will be populated by a suite of quantitative and qualitative performance indicators and a series of milestones and deliverables aligned to the MIP. The IPAAF will provide a simple but effective way to report progress whilst avoiding the overuse of statistics and traffic light systems.

When the Panel previously reported, although the IPAAF was in the early stages of development, it was hoped that it would be fully worked up by the end of December 2019. Unfortunately, that has not come to fruition.

Whilst there has been some progress in the right direction, it has not been as significant or as timely as the Panel would have hoped for. As such, it is now likely to be the end of March 2020, before the IPAAF can be meaningfully utilised as the basis for reporting evidence of progress. That means that the assessment of progress provided for this quarter is again more narrative than the Panel would have wished for.

The remainder of this section briefly explains what progress has been made to date in developing the IPAAF and what now needs to be progressed in the next period.

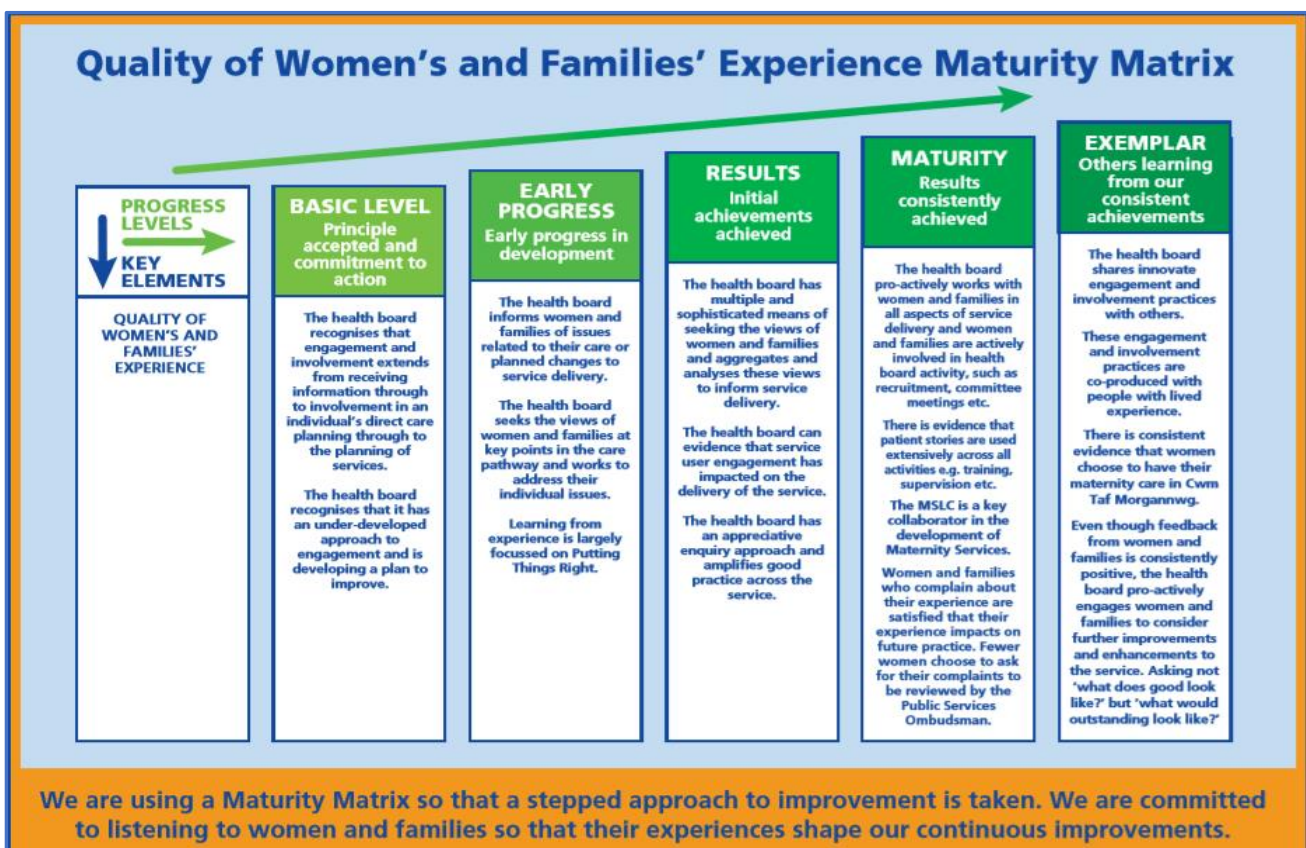
6.1 UTILISING THE IPAAF – PROGRESS TO DATE

The Health Board has now developed the Maternity Improvement Maturity Matrix which, in conjunction with the IPAAF, will provide an assessment of progress across the three domains. This is a positive step which involved a significant amount of work for the Health Board and builds on good practice in other areas. The Maturity Matrix describes five levels of progress using a series of narrative descriptors, as follows:-

- **Basic** (Principles accepted and commitment to action)
- **Early Progress** (Evidence of early progress and developments)
- **Results** (Initial milestones and results achieved)
- **Maturity** (Results consistently achieved)
- **Exemplar** (Others learning from our achievements)

An example of what the Maturity Matrix looks like is provided below using the descriptors for the Quality of Women’s Experience domain.

Figure 2: Example of Maturity Matrix



The first assessments against the Maturity Matrix have recently been undertaken on a trial basis and all three domains have been assessed by the Health Board at 'Early Progress' level. The aim is to progressively move from the left to the right of the Maturity Matrix (i.e. from Basic to Exemplar) across the three domains as the programme matures.

In addition to developing the Maturity Matrix, in conjunction with the Panel and the NHS Delivery Unit, the Health Board has now identified a suite of key metrics in each of the three domains and has begun to produce run charts and graphs going back to April 2019. These require further refinement but the information is already beginning to inform improvement actions. For example, multidisciplinary working groups have already been established in order to identify methods to reduce caesarean section and induction of labour rates; areas where the Health Board performs less favourably than other Health Boards within Wales.

There are also areas of the IPAAF, in particular the Quality of Women's Experience domain where the indicators which are currently in place, are not sufficiently well developed and additional work will be required to create new metrics.

In addition to these process developments, a number of other building blocks have been put in place which will support the application of the IPAAF. In particular:-

- the Maternity Improvement Programme has now been restructured around the three domains with three project groups focusing on Safety and Effectiveness, Quality of Women's Experience and Quality of Leadership and Management;
- the information which is being provided to the Maternity Improvement Board and the Panel has been rationalised and a series of more succinct highlight reports have been introduced focusing on delivery, risk and assurance;
- the programme of monthly assurance visits is now well established and this enables the Panel to test out and triangulate the information which is provided by the Health Board through interaction with staff and patients and by examining and assessing evidence provided by the Health Board.

Although these developments are all steps in the right direction, the IPAAF is not yet being utilised as intended and it is important that the pace of progress is accelerated in the next quarter.

6.2 DEVELOPMENT OF THE IPAAF – NEXT STEPS

In identifying priorities for the next three months, the Panel and the SRO for the Maternity Improvement Programme, have agreed that there will be a concerted focus on completing the development of the IPAAF. The agreed ambition is that by the time the Panel reports in Spring 2020:-

- the framework will have been populated with a suite of performance metrics and work will have been initiated to fill gaps;
- run charts and other performance tools will be available to inform performance reporting and decision making;
- actions and deliverables from the MIP will aligned to each domain;
- a baseline will have been developed in order to identify stretching but realistic improvement targets over time.

(NEXT STEPS 7: The Panel will work closely with the Health Board to further develop the IPAAF and to ensure that the necessary development work is completed in time to enable the framework to be used as the basis for reporting progress during Spring 2020).

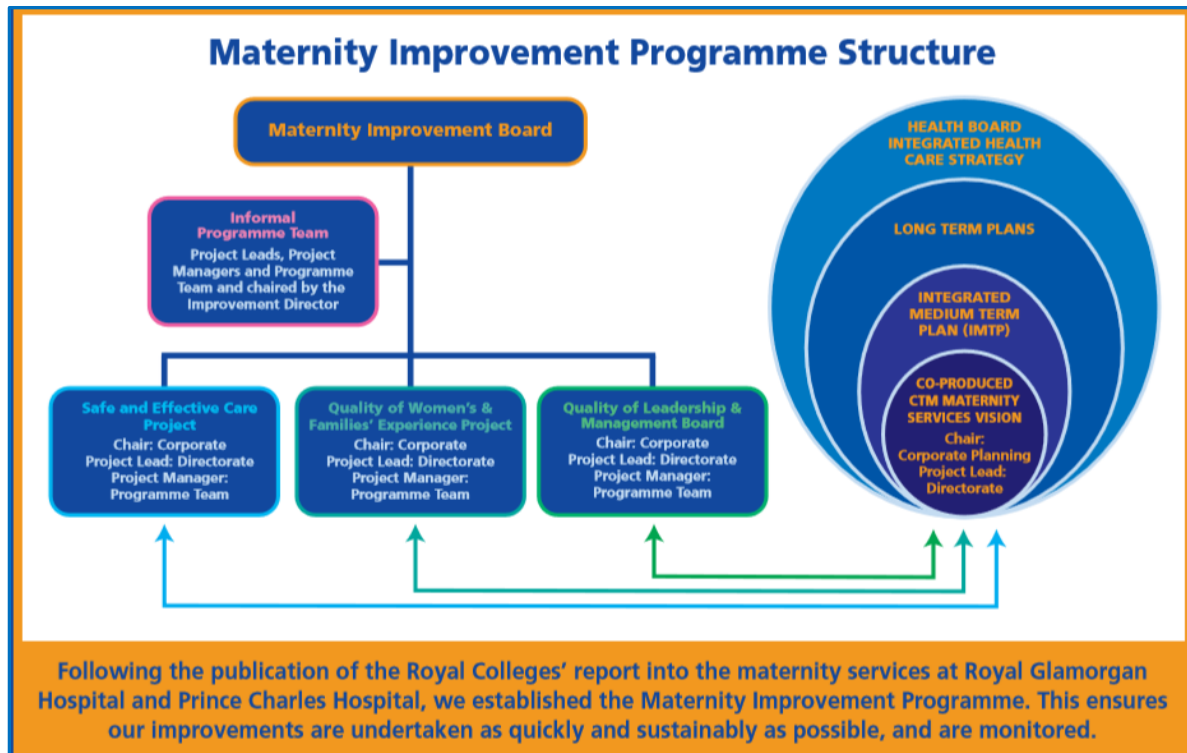
7 HEALTH BOARD RESPONSE

The Health Board response to the Royal Colleges' review was explained in some detail in the Panel's previous report. As such, it is not repeated here, other than to briefly summarise the current position, which is as follows.

The Executive Director of Nursing and Midwifery has been appointed as Senior Responsible Officer (SRO) for the Maternity Improvement Programme. He chairs a Maternity Improvement Board (MIB) reporting to the Health Board through the Quality and Safety Committee. Three discrete Project Groups have been established under the MIB to deliver the Maternity Improvement Plan (MIP) and a Maternity Improvement Team has been established, led by the Maternity Improvement Director to co-ordinate their work. There is ownership and engagement of the improvement process at Board level and clear lines of reporting and accountability.

Over the past three months, the programme structure has evolved, most notably to align it to the IPAAF domains. A fourth strand of work has also been initiated to develop a long-term strategy called 'Maternity Vision' which will align closely with the national strategy for maternity services which is being developed in partnership with the Welsh Government. The current structure is summarised in Figure 3 below.

Figure 3: Maternity Improvement Programme Structure



The SRO has worked collaboratively with the Panel and a constructive working relationship has developed, albeit within an atmosphere of scrutiny and challenge.

The Maternity Improvement Director is working increasingly effectively with the Panel’s Business Manager to manage the oversight and improvement processes in a collaborative way. The Director is critical to the success of the programme and there has been a noticeable increase in the pace of progress since she took up post in August 2019.

Although there are still some administrative issues which need to be addressed and there have been some issues with resilience and capacity (see Section 7.2) in general terms, the arrangements are generally working well and the communication between the Health Board and the Panel is gradually improving.

Recently, the volume of narrative information being presented to the Panel has been streamlined and the business cycle is now based on a series of highlight reports which also support the MIB process, thereby reducing duplication of effort and unnecessary bureaucracy.

7.1 CREATING THE FOUNDATIONS FOR SUSTAINABLE IMPROVEMENT

In Section 10 of its Autumn Quarterly Report, the Panel identified 12 areas where it expected to see the Health Board make substantial progress during October, November and December 2019. These ‘Next Steps’ ambitions are set out in the table below together with a brief assessment of the current position against each.

Table 2: Summary of Progress against ‘Next Steps’ as at 31 December 2019

Anticipated Next Steps	Summary of Progress as at 31 December 2019
<p>1. Remaining leadership posts (in particular the substantive Director of Midwifery position) will be filled.</p>	<p>DELAYED PROGRESS has been made; a Director of Midwifery has now been appointed and will take up post early in January 2020. There has been a delay in filling the post, compounded by the subsequent (and well judged) decision to re-advertise at a higher grade and the requirement for the successful candidate to serve a notice period. In the meantime, the interim Head of Midwifery has provided strong, visible and effective leadership in driving the improvement process forward. The appointment of the substantive Director of Midwifery is a significant milestone as the leadership triumvirate of medical, clinical and managerial directors will soon be in place on a substantive basis. This should allow for an increase in pace and cohesion in delivering against the MIP.</p>

<p>2. Programme resources required to deliver the MIP will be fully in place.</p>	<p>SOME PROGRESS has been made but some posts remain unfilled due to long lead times in the recruitment process. However, it is now anticipated that the full programme team will be in place by the end of January 2020. A lack of capacity, compounded by resilience issues linked to unavoidable sickness absence has hindered progress against the MIP in some areas. However, as outlined in Section 7.2 below, additional capacity and a revised team structure have been agreed with the SRO which should lead to an increase in pace and improved administrative efficiency going forward.</p>
<p>3. Greater Medical involvement in the improvement process.</p>	<p>GOOD EARLY PROGRESS has been made following the appointment of the new Medical Director, a new Clinical Director for Obstetrics and Gynaecology and the recruitment of a number of new consultants. There is now a much greater medical involvement in the improvement process and clear signs that the more visible and engaged leadership which is being provided, in particular by the Clinical Director, is starting to have an impact. Senior medical staff are now taking greater ownership of the safety and quality agenda and there is now a well-defined multi-disciplinary approach to governance. There is still a great deal of work to be done but the leadership structure is now in place which should enable an increase in the pace of delivery. It is reassuring to see senior medical staff now leading working groups seeking to find ways to improve key areas of performance such as rates of caesarean sections and inductions of labour. Both the Medical Director and the Clinical Director are now engaged directly with the Panel.</p>
<p>4. Maternity Improvement Plan will have clearer prioritisation of actions, milestones and deliverables.</p>	<p>LIMITED PROGRESS has been made in re-working the MIP, largely due to capacity and resilience issues within the Maternity Improvement Team and the need to prioritise other pieces of work like the roll out of the Clinical Review Programme. The Chair of the Panel and the SRO have agreed that this is a priority for the next quarter. This is discussed further in Section 8.3 of the report which follows.</p>

<p>5. Further progress against the three 'make-safe' recommendations which remain work in progress, in particular, the Birthrate Plus® review of staffing levels will be completed and an action plan formulated if required.</p>	<p>FURTHER PROGRESS has been made against the three 'make-safe' recommendations which were still assessed as being 'work in progress' at the time of the previous report. Most significantly, the Birthrate Plus® report has been received and indicates that funded establishment level are broadly in line with recommended levels. However, the Panel is still awaiting an action plan to explain how actual staffing levels will be aligned with establishment. This is discussed further in Section 8.2 of the report which follows.</p>
<p>6. Evidence base will be available to enable progress against the remainder of the Royal Colleges' recommendations to be assessed and a more robust level of assurance provided.</p>	<p>GOOD PROGRESS has been made in delivering further against the Royal Colleges' recommendations during October, November and December. The Health Board has presented evidence to the Panel that 27 of the 70 recommendations made by the Royal Colleges have been delivered and embedded in operational practice. The Panel has assessed the evidence and have agreed that 25 of those can be signed off as delivered. The remaining 45 actions, plus 9 more actions identified from associated reviews, remain work-in-progress at various stages of development. A more detailed analysis of delivery against the MIP is set out in Section 8 of this report.</p>
<p>7. 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.</p>	<p>SOME PROGRESS has been made in further developing the IPAAF although less has been achieved than expected. Key performance metrics have been identified and the first iteration of a performance dashboard has been produced. However, due to capacity issues and competing priorities, the work required to identify longer-term targets for performance improvement and timescales has not been completed. The Chair of the Panel and the SRO have agreed that further development of the IPAAF is a key priority for the next quarter. A more detailed assessment of the issues surrounding the development of the IPAAF was set out in Section 6 of the report.</p>

<p>8. Health Board will begin to deliver against the corporate development plan. In particular, work will have commenced in areas critical to maternity service improvement, including leadership development and redefining culture and values.</p>	<p>EARLY PROGRESS has been made by the Heath Board in implementing its wider corporate development programme, particularly in those areas which will have an impact in improving maternity services. It is encouraging to see a degree of correlation between the two programmes with corporate developments now clearly being influenced by lessons which have been learned from the maternity service improvement work which is being undertaken. A summary of the progress which has been made in this area is set out in more detail in Section 7.3 of this report.</p>
<p>9. Progress made around the management of complaints and concerns and the management of patient feedback.</p>	<p>EARLY PROGRESS has been made at both corporate and departmental levels to address some of the fundamental weaknesses which have been identified in the processes for managing complaints and concerns. Some additional capacity has been deployed and progress has been made in meeting the timescales for new referrals. A realistic and achievable action plan has been developed for longer-term improvement which is currently progressing through the Health Board's approval process. A more detailed assessment of progress in this area is outlines in Section 4 of the report.</p>
<p>10. Health Board's Maternity Services interim engagement approach will have moved from planning to implementation with first community-based co-production events involving staff and patients held and evaluated.</p>	<p>GOOD PROGRESS has been made with two of the three community Engagement Events now held and some valuable learning and insights emerging. The third event is scheduled for February 2020. Once the three events have been completed, the product will be evaluated and an action plan drawn up to identify how the information gathered will be used (a) to improve the experience of the women and families using maternity services and (b) to identify ways in which the organisation more broadly can better utilise patient and community feedback to improve its services. A more detailed assessment of the progress which has been made in this area is set out in Section 4.5 of the report.</p>

<p>11. The Welsh Government to commence 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.</p>	<p>GOOD BUT DELAYED PROGRESS has been made in this area. The clinical review strategy is now in place, clinical review teams have been recruited, inducted and trained and supporting systems and processes had been developed ready for the work to begin in December. However, implementation has been deferred until early January 2020 to provide more time for the Health Board to strengthen its arrangements for supporting the women and families whose care will be reviewed. Further details of the progress which has been made in this area can be found in Section 5 of the report.</p>
<p>12. 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.</p>	<p>FURTHER PROGRESS has been made in this area. The Clinical Review Panel has now assessed 11 of the 20 serious incidents which have been recorded since the Royal Colleges conducted their review and has seen a steady improvement in the quality of the investigations and can see evidence that lessons are being learned as a result. There is still work to be done and some recommendations have been made which are being actively addressed by the Health Board. A further review of the remaining serious incidents will be conducted during the next quarter. A more detailed assessment of the progress which has been made in this area is outlined in Section 5.6 of the report.</p>

7.2 MATERNITY IMPROVEMENT TEAM - CAPACITY AND RESILIENCE

Based on the assessment in Section 7.1, on balance, good progress has been made during the last three months, particularly in terms of increasing medical involvement, delivering a further tranche of the Royal Colleges' recommendations and progressing the engagement work with women and families. However, there are other areas, specifically the ongoing development of the IPAAF and the remodelling of the MIP, where the pace of progress has been less than the Panel anticipated and less than had been agreed with the Health Board.

At the beginning of December, it became increasingly clear to the Panel that there was insufficient capacity and resilience within the Maternity Improvement Team to deliver the MIP **and** support the clinical review programme **and** manage engagement and communication with women and families. This lack of capacity manifested itself in other ways, for example:-

- it was necessary to defer the implementation of the Clinical Review Programme by a month because the Panel was not confident that the Health Board had the necessary arrangements in place to support the process and in particular to ensure that the needs of the women and families could be addressed;

- there are ongoing problems in securing data of the right quality to support the clinical review process and the Panel is still not fully confident that the database which the Health Board has developed to facilitate ongoing contact with women and families affected is as robust as it should be;
- there a number of pieces of work which have taken longer to finalise than was expected, in particular the self-referral process which is still in the final stages of development.

Similarly, although in the final analysis, good progress has been made in delivering a further tranche of the Royal Colleges' recommendations (see Section 8 for a more detailed assessment) the evidence required to sign them off as delivered was presented late in the day which created pressure on both the Panel and the Health Board to assimilate the evidence in time for it to be included within the current report.

There have been a number of factors which have hindered the pace of progress, not least some unexpected and unavoidable absence in critical positions within the Maternity Improvement Team and delays in recruiting staff. There have also been changes in circumstances, for instance an expansion of the scope and scale of the clinical review programme which has created additional resourcing implications and increased workloads. An example of this are the requirements for anonymising clinical records.

These issues have been discussed with the SRO and the CEO and there has been an immediate and positive response. Some additional capacity has been identified and a restructuring of the Maternity Improvement Team will take place early in the New Year which will provide greater flexibility to respond to changing demands and fluctuations in workload. In addition, all of the remaining posts are expected to be filled substantively by the middle of January.

This provides the Panel with increased confidence that the process will move forward with increased pace and additional administrative discipline.

(NEXT STEPS 8: By the end of January 2020, all of the resources required to support the Maternity Improvement Programme will be fully in place and the Maternity Improvement Team will be restructured and supplemented to provide greater capacity and increased resilience).

7.3 WIDER HEALTH BOARD DEVELOPMENT PLAN

At an early stage in the improvement process, it was recognised by the Health Board that the underlying causes of the failings which were identified by the Royal Colleges were not confined to maternity services.

As a result, the Health Board designed and has now begun to implement a wider organisational development programme which amongst other issues, will improve leadership and governance at all level and will redefine the culture and values of the organisation. This programme of work is both informed by and complementary to the maternity services improvement work which the Panel oversees.

The Panel has worked closely with the interim Chief Executive and her team to ensure that the programmes of work are aligned.

As part of the development plan, the Health Board has begun a whole system revision of its corporate and quality governance frameworks and processes. A further component is the implementation of a newly agreed organisation wide operating model, which places people and quality firmly at the centre of its approach. The implementation has commenced.

Learning from the maternity services work, the organisation wide development plan is supported by a performance framework based on a Maturity Matrix supported by clear evidence and measures to track progress, which is in early stages of development.

The Health Board has now commenced a values and behaviours programme across the organisation under the 'Let's Talk' banner. The programme is supported by external consultants and has been generally well received by staff with good levels of engagement and positive feedback from participants.

In respect of maternity services in particular, two development programmes have now been rolled out. The first is a leadership programme for Consultants and the Senior Midwifery Leadership Team which was launched on 14 November 2019. The second, also launched in mid-November, is a culture and values programme aimed at all three hundred or so maternity services staff. This will focus on the development of a growth mind-set, compassion, collaboration and emotional intelligence.

Both of these programmes are important developments and their success will be key in addressing some of the underlying cultural issues which run through a significant number of the Royal Colleges' recommendations. As such, the Panel will be monitoring progress with interest during the next quarter.

7.4 JOINT HIW/WAO REVIEW OF QUALITY GOVERNANCE ARRANGEMENTS

Since many of the issues are cross-cutting, during the next quarter, the Panel will be working with the Health Board to ensure that the corporate action plan which is being developed in response to the joint HIW/WAO thematic review of quality governance arrangements is closely aligned with the MIP due to several overlapping themes identified within both the Panel's work and this wider report.

(NEXT STEPS 9: The Panel will work with the Health Board to ensure that where appropriate, the action plan which is being developed in response to the joint HIW/WAO thematic review of quality governance arrangements is closely aligned with the MIP).

8 ASSESSMENT OF PROGRESS AGAINST THE MATERNITY IMPROVEMENT PLAN

As outlined in Section 6 of this report, the Panel anticipates that by Spring 2020, the Integrated Performance Assessment and Assurance Framework (IPAAF) will be populated with prioritised metrics and key milestones and deliverables against the MIP.

This will enable the Panel and the Health Board to provide a more evidence-based assessment of progress using a richer blend of qualitative and quantitative measures combined with evidence of delivery against the Royal Colleges' and other associated recommendations.

It will also provide the basis for the initial baseline assessment against the Health Board's Maturity Matrix and enable performance targets and trajectories to be developed which can then be monitored and used to evaluate progress over time. This is particularly important given that significant improvements in some key areas, including lower caesarean section and induction of labour rates, will take a significant period of time to achieve.

In the interim, whilst the IPAAF is still under development, the Panel's assessment of progress for the quarter under review, is necessarily based on:-

- evidence of further progress against the 11 'make-safe' actions identified by the Royal Colleges in January 2019;
- evidence of delivery against the 79 recommendations in the Maternity Services Improvement Plan;
- information drawn from a range of other sources, including reports from external bodies and from the Panel's now regular monthly assurance visits.

The evidence which is available in these three areas is summarised in the following sections.

8.1 FURTHER PROGRESS AGAINST RCOG 'MAKE-SAFE' ACTIONS

When the Panel produced its first report progress in September 2019, it focused on assessing progress against the eleven 'make-safe' actions which were identified by the Royal Colleges as requiring immediate attention due to potential safety implications.

Having assessed a range of evidence provided by the Health Board, the Panel concurred with the Health Board's assessment that eight of the eleven actions had been addressed and were now embedded in operational practice. Although significant progress had been made against the other three actions, at that stage, they remained work in progress.

The three 'make-safe' recommendations which remained in progress are set out in the table below together with an update on further developments which have taken place since September 2019.

It is important to emphasise that the Health Board has put measures in place to mitigate any potential adverse consequences and at this stage, the risk to public safety is no longer imminent as a result of the immediate actions which were undertaken.

Table 3: Progress against 'Make-Safe' Action

'Make-Safe' Action	Further Progress Update	Current Status
<p>6. There was a lack of awareness and accessibility to guidelines, protocols, triggers and escalations.</p>	<p>Protocols, etc. are in place and accessible for PCH and RGH but further work to be done post-merger to align with Princess of Wales (POW). This is expected to be completed by March 2020. Ongoing work to ensure compliance taking place in all three hospitals.</p>	<p>Remains work in progress until POW work complete then reassess evidence of compliance across three sites.</p>
<p>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.</p>	<p>Interim levels in place based on professional judgement awaiting Birthrate plus® report.</p> <p>Compliance monitored by Health Board on a daily basis and by Welsh Government through weekly monitoring process.</p> <p>Birthrate plus® Review received in November 2019. Review indicates that existing establishment levels broadly align with Birthrate plus® recommendations and no additional resourcing required.</p> <p>Action to bring actual number up to funded establishment now in place. There are currently six vacancies in PCH of which four have been filled and two are still to be recruited.</p>	<p>Remains work in progress. Panel awaiting sight of action plan before reassessing whether the recommendation can be signed off.</p>
<p>11. The culture within the service is still perceived as punitive. Staff require support from senior management at this difficult time.</p>	<p>Significant amount of staff and leadership development activity underway but culture change takes time. There are early signs of improving multidisciplinary engagement in meetings and improvement work but still too early to sign off as completed.</p>	<p>Remains work in progress.</p>

During December 2019, the Panel again reviewed the evidence of progress and concluded that whilst further progress had been made against all three recommendations, none could yet be signed off as complete. Therefore, they remain work in progress and the Panel will continue to monitor them during the next quarter.

8.2 PROGRESS AGAINST THE MATERNITY IMPROVEMENT PLAN

The Health Board's MIP contains 79 actions, 70 of those derived directly from the Royal Colleges' recommendations and the remainder derived from associated reviews or actions identified by the Health Board from its own analysis.

As of 13 December 2019, the Health Board reported that 36 (46%) of the 79 recommendations had been completed. The distribution of the 36 recommendations against the constituent project groups is illustrated in the figure below.

Figure 4: Summary Progress against MSIP Recommendations



During December 2019, the Health Board presented evidence in respect of 27 of the 36 recommendations for assessment by the Panel. The Panel concluded that 25 of those recommendations were ready for 'sign-off' as completed whilst the other two recommendations required further work before they could be considered complete.

A schedule of the 25 actions which have been signed off as completed by the Panel is included in 'Appendix D'.

The schedule also provides a summary of the evidence which was assessed by the Panel in order to reach a decision. It will be seen from the schedule that a range of recommendations have now been completed, most notably:-

- the development of a clinical audit process and improvements in the processes for recording, investigating and learning the lessons from serious incidents;
- improvements in the quality of training for both medical and midwifery staff together with increased rates of compliance and robust plans for future delivery;
- the creation of a comprehensive clinical governance framework with clear evidence that this is now operating and resulting in improvements in clinical practice.

A number of these recommendations will need to be revisited periodically over the next six to twelve months to ensure that they have been fully embedded in operational practice. The Panel will build this follow-up work into its programme of assurance visits going forward.

Despite the obvious progress identified in this report, there is still a great deal of work to be done to deliver against the remainder of the recommendations from the Royal Colleges' review and the other associated recommendations and also to ensure that the improvements which have been delivered so far are embedded in practice and sustainable in the longer term.

Over two-thirds (68%) of the actions in the MIP remain work in progress (based on what the Panel has signed off as delivered) and many of those will require changes in culture and operational practice to fully deliver them. This is something which experience elsewhere shows will not be delivered overnight. As such, there is no room for complacency and a real focus needs to be maintained on delivery going forward.

(NEXT STEP 10: The Panel expects to see further delivery against the remaining recommendations within the Plan and a focus on embedding those which have already been delivered into operational practice).

8.3 DEVELOPING THE MATERNITY IMPROVEMENT PLAN

Although steady progress has been made in delivering against the actions in the MIP, the Plan itself is now in need of further development. Although it has performed a purpose to this point, it currently lacks structure and prioritisation and is not dynamic; for instance, it does not encapsulate emerging issues.

It is effectively a list of recommendations, many of them overlapping, rather than a detailed plan about how those actions will be delivered, when and with what outcome. All of this means that the plan is unwieldy and the administration and oversight of it, is more complicated than it ought to be. The Chair of the Panel and the SRO have agreed that this is a priority for the next quarter.

(NEXT STEPS 11: As a matter of priority, the Maternity Improvement Plan needs to be developed into a more dynamic, better prioritised plan with clear milestones, targets and deliverables).

8.4 OTHER SOURCES OF INFORMATION AND EVIDENCE

Whilst the Panel has focused on ensuring that there is an evidence base to demonstrate progress against the MIP, there has also been other information, which indicates that services are improving and that this is having a positive impact on the experience of women and families. For example:-

- over the past three months, the twice weekly surveys conducted by the Health Board's Patient Advice and Liaison Service (PALS) have identified consistently high levels of satisfaction from women using the services at PCH and there is evidence of increasingly positive feedback from women and families about the quality and dignity of care provided in the Tirion Birth Centre at RGH;
- the more positive feedback from women and families is corroborated to a significant degree by a report which was recently published by the Cwm Taf Morgannwg Community Health Council (CHC) following unannounced visits to Prince Charles and Royal Glamorgan Hospitals during June, July and September 2019;
- recent reports from Health Education and Improvement Wales (HEIW) have highlighted incremental improvements in the training and education environment for medical staff working in the obstetrics team, albeit that there are still some areas which require further attention.

Perhaps the most promising indicator of progress to date is provided by Healthcare Inspectorate Wales (HIW) which published its report into an unannounced three-day inspection of the Tirion Birth Centre at RGH in September. This report, which was published on 13 December 2019, concludes overall that '*care was provided in a safe and effective manner*' whilst '*staff demonstrated a clear passion and drive to provide high standards of care to patients, in a homely, relaxed environment*'. There were a small number of areas for improvement, but these did not indicate fundamental weaknesses within the service.

The Health Board are currently awaiting the publication of an unannounced inspection of the consultant led-service provided at PCH which was conducted in November 2019. This is expected to be published shortly and will provide the most significant external assessment yet of the progress which has been made.

8.5 OVERALL ASSESSMENT OF PROGRESS AGAINST THE MIP

Taking account of the progress which has been made against the Maternity Improvement Plan, the further progress made against the 'make-safe' actions and the more positive narrative emerging from external reviews and other sources, the Panel believes that that the Health Board has made good progress during October, November and December 2019. However, a substantial amount of work still remains to be done and there is a need for the MIP to be further developed.

9 CONCLUSIONS AND NEXT STEPS

Whilst significant work remains to be done to deliver fully against the Royal Colleges' recommendations, the Panel believes that on balance, the Health Board has made good progress during October, November and December 2019. As such, the Panel is now cautiously optimistic that longer-term sustainable improvement in maternity services will be delivered in due course.

There is tangible evidence of further delivery against the 79 recommendations set out in the Royal Colleges' report and associated reviews and there are clear indications, supported by information from a range of internal and external sources, that the service is improving more generally.

The majority of the progress which has been made is in the Safe and Effective Care domain. In particular, the creation of a comprehensive clinical governance framework with evidence that this is now operating and resulting in improvements in clinical practice, is a significant step forward. Similarly, the development of a clinical audit process and ongoing improvements in the processes for recording, investigating and responding to serious incidents provide solid foundations on which to build a safer and more effective service going forward.

There has also been progress in the Quality of Leadership and Management domain, particularly in respect of training and development for medical and midwifery staff. It is also encouraging that leadership and cultural development programmes have been launched across the Health Board, with two programmes specifically targeted in maternity services.

Meanwhile, there has also been progress with the clinical review programme which is now ready for implementation and significant steps forward have been made in terms of engaging more effectively with women and families.

Against that background of overall progress, there has been some slippage in the development of the IPAAF and the re-development of the MIP which will need renewed focus in the next quarter. This will enable the next quarterly report to be more evidence based and outcome focused.

There is also a need for increased pace and administrative discipline in the way that the Health Board is managing the improvement process and constructive discussions have taken place to agree a revised structure and an increase in capacity which will address that.

At various points in the report, 'next steps' have been identified which are reflected in the priorities set out below.

9.1 KEY PRIORITIES FOR THE NEXT QUARTER

The key priorities which the Panel has agreed with the SRO for the next three months are as follows:-

- completing the engagement events with women and families, assessing the outcomes and developing a plan to reflect the lessons learned in operational delivery (Next Steps 1,2 and 3);
- monitoring the implementation of the Complaints and Concerns Improvement Plan and incorporating the metrics which are developed to monitor improvement into the IPAAF (Next Step 4);
- progressing the clinical review process to implementation stage with a specific focus on supporting the women and families involved (Next Steps 5 and 6);
- further developing the IPAAF with more sophisticated metrics, clearer priorities and stretching but achievable improvement targets over time (Next Step 7);
- ensuring that by the end of January 2020, all of the resources required to support the MIP are in place and that the Maternity Improvement Team is restructured and supplemented to provide greater capacity and increased resilience (Next Step 8);
- ensuring that where appropriate, the action plan which is being developed in response to the joint HIW/WAO thematic review of quality governance arrangements is closely aligned with the MIP (Next Step 9);
- further delivery against the remaining recommendations within the Plan and a focus on embedding those recommendations which have already been delivered into operational practice (Next Step 10);
- developing those elements of the MIP which remain to be delivered into a more dynamic and constantly evolving document with clearer actions, milestones for delivery and measurable outcomes (Next Steps 11).

All of these issues will be monitored and tracked through the Panel's monthly business cycle and reported upon when the Panel provides its next quarterly update report to the Minister.

9.2 RECOMMENDATIONS

In view of the steady progress which is being made and the ongoing commitment which the Health Board has shown to the improvement process, the Panel does not feel that it is necessary to make any specific recommendations at this stage.

10 LIST OF APPENDICES

Appendix A: Terms of Reference

Appendix B: The Visual Map: Improving Maternity Together (Merthyr Tydfil)

Appendix C: Integrated Performance Assessment and Assurance Framework

Appendix D: Schedule of Completed Maternity Improvement Plan Recommendations

Independent Maternity Services Oversight Panel

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

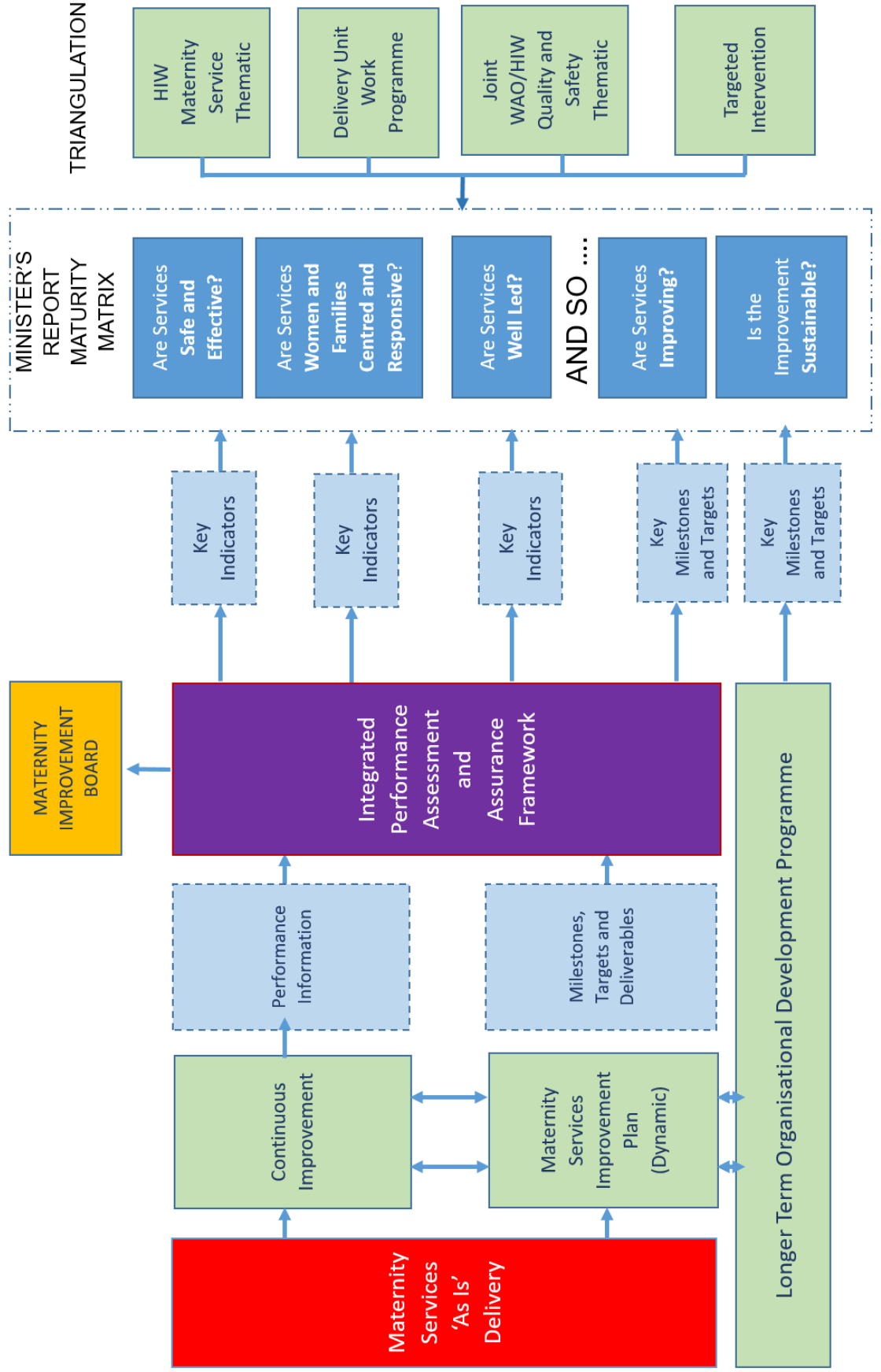
- Establish robust arrangements which provide assurance to stakeholders that the recommendations of the Royal Colleges' review and other associated recommendations are being implemented by the Health Board. Set and agree milestones and deliverables and track progress against them;
- Establish and agree an independent multidisciplinary process to clinically review the 2016-2018 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.

¹By 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.

The Visual Map: Improving Maternity Together – Merthyr Tydfil Engagement Event



Cwm Taf Morgannwg University Health Board Integrated Performance Assessment and Assurance Framework



Schedule of Completed Maternity Improvement Plan Recommendations Recorded as Completed During Quarter Two (October to December 2019)

The Health Board's Maternity Improvement Plan contains 79 actions, 70 of those deriving directly from the Royal Colleges' recommendations and the remainder deriving from associated reviews or actions identified by the Health Board from its own analysis.

During December 2019, the Panel assessed supporting evidence provided by the Health Board and agreed that 25 actions had been progressed in Quarter Two and were ready for 'sign-off' as completed. Three further actions were agreed to be very close to completed but sign off was deferred until the next quarter pending further verification.

The 25 of 79 completed actions are in addition to the 8 'make-safe' recommendations which were agreed as completed at the end of Quarter One. That brings the total number of the 79 actions now completed as at 31 December 2019 to 33.

Details of the 25 actions which were signed off as completed during Quarter Two are set out in the table below, grouped by project group. In some cases, the Panel felt that a follow-up review was necessary to ensure that the action is embedded in practice and where that is the case, it is indicated in the table and further checks will be scheduled into the Panel's programme of assurance visits going forward.

It is important to recognise that it is for the Board to develop its own assurance that there is sufficient evidence to sign off the recommendation as complete. The role of the Panel is to quality assure the Health Board's evidence to provide assurance to the Minister and other stakeholders that the Health Board's assessment is reasonable based on the evidence available.

PROJECT WORKSTREAM: Safe and Effective Care

Action Ref:	Source	Recommendation	Agreed as Completed	Follow-Up Required?	Summary of Response and Evidence Provided
7.3	RCOG	Clinical Audit - Mandate and support a full programme of clinically led audit with a nominated consultant lead to measure performance and outcomes against guidelines.	16.12.19	Health Board determined.	<ul style="list-style-type: none"> - Lead nominated May 2019. - Audit Plan agreed via Governance structure. - Audit plan monitored via the Audit and Research Forum. - Appointment of a research midwife to support recruitment into national research projects scheduled for 2020 with funding provided by the HB research programme.
7.4	RCOG	Monitoring Clinical Practice - Ensure monitoring of clinical practice of all staff is undertaken by the Clinical Director and Head of Midwifery (i) to ensure compliance with guidelines (ii) to ensure competency and consistency of performance is included in annual appraisal.	16.12.19	Health Board determined.	<ul style="list-style-type: none"> - Personal Development Reviews in place for all staff. - Clinical reflection sessions embedded into all of the units. - PCH and POW sessions are multidisciplinary. These sessions support discussion and challenge in relation to clinical guidance. - Clinical incident meetings are held in both Obstetric units. MDT attendance supports the identification of variation in practice and lessons learnt which are communicated via the monthly risk newsletter or for immediate safety issues via the 'Safety Briefings'. - The clinical dashboard is shared with staff to ensure clinicians have regular information on outcomes. - The Caesarean section and Induction of Labour Reduction groups developed to provide clinical challenge in relation to compliance to national or local guidance.
7.9	RCOG	Trigger Lists - Develop a trigger list for situations which require consultant presence on the labour ward which must be (i) agreed by all consultants in obstetrics, paediatrics and anaesthetics and senior midwives (ii) audited and reported on the maternity dashboard.	16.12.19	Health Board determined.	<ul style="list-style-type: none"> - Trigger list developed and embedded within the MITS system. - Datix data reported via the dashboard to monitor reporting rates; - The Directorate is currently using the draft Serious Incident Trigger List developed by Heads of Midwifery. This is currently being reviewed by the National Maternity and Neonatal Network and the HB has representation on the group.

7.10	RCOG	Risk Management Meetings - Introduce regular risk management meetings which must be (i) open to all staff (ii) conducted in an open and transparent way (iii) held at a time and place to allow for maximum attendance.	16.12.19	6 month Panel follow-up to ensure embedded.	<ul style="list-style-type: none"> - Clinical governance dates are displayed in each clinical area. - All staff informed by email with copy of the agenda attached. - Weekly incident review meeting established. - The dedicated foetal surveillance Midwife, monitors DATIX reporting of any patients that fall in the Growth Assessment Protocol (GAP). Any concerns that are identified are fed in the weekly incident review meeting. This midwife also provides GAP training once a month on mandatory training days for staff members. - Range of evidence (posters, attendance sheets, newsletters, minutes of meetings, presentations, etc.) presented as evidence that practice is now operating routinely with good levels of engagement. -
7.11	RCOG	Mandatory Meetings - Ensure mandatory attendance at the following meetings for all appropriate staff. Attendance must be recorded and included in staff appraisals. Ensure that meetings are scheduled or elective clinical activity modified to allow attendance at (i) governance meetings, (ii) audit meetings (iii) perinatal mortality meetings.	16.12.19	6 month Panel follow-up to ensure embedded.	<ul style="list-style-type: none"> - All day Governance meeting now in place. - Attendance register completed and available for inspection demonstrating good levels of MDT attendance - Attendance at forums managed via governance structure resulting in Health Board wide participation by all clinicians in the forums (including POW since April 2019) - Senior management reporting practice now embedded in culture.
7.12	RCOG	MDT Debriefings - Undertake multidisciplinary debriefing sessions facilitated by senior maternity staff after an unexpected outcome.	16.12.19	Health Board determined.	<ul style="list-style-type: none"> - MDT de-briefing process now in place; - Records of debriefs and attendance available and inspected. - Training and development of maternity team and benchmarking of similar sessions taking place. (SBAR available).

7.14	RCOG	Consultant Meetings - Consultant meetings should (i) be regular in frequency, (ii) have a starting agenda item on governance (iii) be joint meetings with anaesthetic and paediatric colleagues.	16.12.19	Health Board determined.	- Consultant meetings are held monthly, a dedicated one hour slot is allocated at each Governance Day. There is a pre-circulated agenda, with attached minutes of the previous meeting. All maternity staff are invited to attend, along with anaesthetics and paediatric colleagues. Evidenced - By the attached attendance list.
7.16	RCOG	Consultant Availability - Urgent steps must be taken to ensure that consultant obstetricians are immediately available when on call (maximum 30 minutes from call to being present).	16.12.19	Ongoing quarterly checks by Panel to ensure continued compliance.	- Policy in place and re-enforced. Availability is monitored and escalated where there are concerns. Compliance tested by Panel. - Risk team monitor through incident reviews, the number of occasions the consultant is called 'out of hours' and arrives within the 30 minute recommended response time. - Risk midwife maintains records for inspection. - For 2020 this will be included in the annual record keeping audit undertaken by midwifery and medical staff. Compliance against this standard will then be reported via the audit plan. - Consultants have been provided with accommodation on site where required with dedicated O and G Consultant flat.
7.21	RCOG	Incident Reporting - Improve incident reporting by (i) delivering training on the use of the Datix system for all staff, (ii) encouraging the use of the Datix system to record clinical incidents, (ii) monitor the usage of the incident reporting system	16.12.19	Ongoing quarterly checks by Panel to ensure continued compliance.	- All staff have will have received Datix training by end of March 2021. - Updates to be provided through annual training programme; - Staff report being more confident to report and the trigger list linked to the MITS supports the maintenance of good levels of reporting.

7.23	RCOG	Learning from Serious Incidents - Improve learning from incidents by sharing the outcomes from SIS on a regular basis and in appropriate, regular and accessible format.	16.12.19	Continuous Health Board monitoring.	<ul style="list-style-type: none"> - All serious incidents are now reviewed by the MDT; - Learning from Serious Incidents is shared within the Clinical Board and Directorate via (i) Governance newsletter (ii) Clinical audit minutes from Governance Day (iii) Obstetrics Quality and Safety agendas (iv) action plan monitoring - Range of evidence made available for inspection by Panel including (i) incident review meeting attendance sheets (ii) incident reporting newsletters (iii) minutes of audit items in governance day meetings, (iv) minutes from staff meetings (v) Quality and Safety meeting agendas.
7.26	RCOG	Joint Neonatal and Maternity Audits - Agree jointly owned neonatal and maternity services audits of neonatal service data including, neonatal outcome data, perinatal deaths, transfer of term babies to SCBU, babies sent for cooling, Each Baby Counts reporting, MBRRACE reporting, breast feeding rates, skin to skin care after birth, neonatal infection, Baby Friendly accreditation, Bliss Baby Charter accreditation.	16.12.19	6 month Panel follow-up to ensure embedded.	<ul style="list-style-type: none"> - Audit Plan in place and compliance being monitored - National Reporting arrangements being follows. - Forums in place and currently monitor audit performance. - Minimum targets to be set for expected performance via IPAAF framework.
7.36	RCOG	Clinical Supervision and Consultant Oversight - Clinical supervision and consultant oversight of practical procedures must be in place of all staff including specialist midwives and doctors.	16.12.19	Health Board determined.	<ul style="list-style-type: none"> - Consolidation into one obstetric unit with increased hours of resident Labour Ward cover from 40 hours to 60 hours per week - Reduction in handovers from 4 to 2 in any 24 hour period allowing for consultant Labour Ward cover. - All consultants complete ward rounds as part of their job plans. - HEIW Medical Deanery feedback suggest no longer an issue for trainees. - Updates on weekly clinical dashboard. - Tested through Panel observations and conversations with staff.

7.38	RCOG	Consultant Ownership on Ward - Ensure the consultant on-call for the labour ward has ownership of all patients in the maternity unit for the period in the maternity unit during the period on-call. This must involve the antenatal ward round being performed by the consultant.	16.12.19	Ongoing Health Board checks.	<ul style="list-style-type: none"> - Consolidation into one obstetric unit with increased hours of resident Labour Ward cover from 40 hours to 60 hours per week - Reduction in handovers from 4 to 2 in any 24 hour period allowing for consultant Labour Ward cover. - HEIW Medical Deanery feedback suggest no longer an issue for trainees. - Updates on weekly clinical dashboard. - Tested through Panel observations and conversations with staff. - ANC job plans provided and inspected by Panel.
7.59	RCOG	Pre-Merger Risk Assess - Urgently carry out a full risk assessment before committing to the merger on 9 March 2019 to ensure women's safety, including ensuring that length of stay is reduced safely to allow for sufficient capacity in the new merged unit.	16.12.19	Completed pre-merger.	<ul style="list-style-type: none"> - Risk assessment prior to move undertaken. - Risk assessment reviewed at board level. - Daily Acuity reports completed to ensure monitoring. - PCH operating regularly to full capacity. - Opportunities to increase usage of MLU at RGH.
7.60	RCOG	Monitoring Reduced In-Patient Capacity - Monitor the effects of the reduced inpatient capacity to avoid any adverse effects on the safety or quality of the service.	16.12.19	Completed pre-merger.	<ul style="list-style-type: none"> - Daily Acuity reports are completed to ensure monitoring. - Process monitored on weekly basis by WG to ensure compliance. - PCH operating regularly to full capacity.
7.61	RCOG	Increase In-Patient Capacity – Develop a plan to increase inpatient capacity if that is seen to be required.	16.12.19	Ongoing monitoring.	<ul style="list-style-type: none"> - DATIX monitoring in use and overflow area available. - Regular regional contingency planning meetings in place. - All out of area bookings monitored through a dedicated staff member within the informatics department. - Currently no requirement to increase inpatient capacity (last assessed September 2019) but ongoing monitoring taking place.

7.65	RCOG	Criteria for New FMU - Ensure that criteria for the opening of the new FMU have been agreed by a multidisciplinary maternity guidelines group and that readiness for the merger is assured.	16.12.19	Completed pre-merger.	- SOP approval and escalation via the governance framework.
7.66	RCOG	Risk Register - Update the risk register and review regularly at Board level.	Risk register not available and Panel therefore unable to verify.	Deferred to next reporting period.	- Minutes from the forums and cooperate committee. - Risk register presented to Q and SR Committee (not available for inspection).

PROJECT WORKSTREAM: Quality of Leadership and Management

Action Ref:	Source	Recommendation	Agreed as Completed	Follow-Up Required?	Summary of Response and/or Evidence Assessed
7.6	RCOG	O and G Consultant Standard Induction Programme – O and G consultant staff must deliver (i) standard induction programme for all new junior medical staff (ii) standard induction programme for all locum doctors.	16.12.19	6 month Panel follow-up to ensure embedded.	<ul style="list-style-type: none"> - Induction programmes have been established by the Directorate. - Evidenced through feedback from junior medical and locum staff via internal surveys and feedback to HEIW Medical Deanery and GMC. - Documentary evidence presented to Panel (e.g. HEIW Targeted Visit report, Directorate Locum Induction Guide, Locum Induction Feedback Forms, 360 degree appraisal template)
7.13	RCOG	Clinical Lead, Governance - Identify a clinical lead for governance from within the consultant body. This individual must (i) be accountable for good governance (ii) attend governance meetings to ensure leadership and engagement	16.12.19	6 month Panel follow-up to ensure embedded.	<ul style="list-style-type: none"> - Clinical Director appointed and identified as clinical lead for governance. Evidence that responsibilities assumed through meeting minutes, documents and regular briefing notes shared with Panel; - Consultant lead for Risk and Governance appointed. - Documentary evidence provided to Panel (Governance day attendance and minutes, identification of governance leads).

7.25	RCOG	<p>Consultant and Midwife Clinical Audit and Quality Improvement Leads - Appoint a consultant and midwifery lead for clinical audit/quality improvement with sufficient time and support to fulfil the role to ensure (i) clinical audits are multidisciplinary (ii) there is a clinically validated system for data collection (iii) that the lead encourages all medical staff to complete an audit/quality improvement project each year to form part of their annual appraisal dataset (iv) sharing of the outcomes of clinical audits and the performance against national standards.</p>	16.12.19	6 Month Panel follow-up.	<ul style="list-style-type: none"> - There is multi professional attendance at clinical audit sessions. - Appointment of consultant and midwifery audit leads taken place. - All medical staff required to complete an audit/quality improvement project each year / revalidation cycle to form part of their annual appraisal dataset. - The sharing of audit outcomes takes place through presentation at governance days. - The individual audits are registered and recorded through the Clinical Audit Department. - Panel presented with evidence via attendance lists, agendas and meeting minutes for governance day and forums.
7.28	RCOG	<p>Executive Lead to Board - Ensure that the executive level lead role for maternity will work with the maternity department and this role is effective and supported. This individual should (i) have a direct progress reporting responsibility to the Board, in particular while the issues raised in this report are being resolved (ii) understand and facilitate improvement in the reporting of safety issues and clinical risk (iii) provide a single point of reference for liaison with external agencies (iv) ensure all reports from external agencies and regulators are channelled through a single pathway to ensure priorities remain focussed.</p>	16.12.19	Health Board determined	<ul style="list-style-type: none"> - There is dedicated executive lead role for maternity in place who is also the SRO for the Maternity Improvement Programme - This lead conducts regular ward walk-arounds and escalates any findings of concern directly to the senior leadership and/or to Board via governance arrangements. - Panel has directed involvement with the SRO and the accountability and delivery framework which has been established and that all of the responsibilities specified by the RCOG are carried out effectively.

7.34	RCOG	Clinical and Educational Supervisors - Allocate all trainees currently in post a clinical and educational supervisor. The role of clinical supervisor and educational supervisor should be documented and closely monitored by the Director of Medical Education. The competency assessments for trainees must be provided in-house under the supervision of the RCOG College Tutor.	16.12.19	6 month Panel follow-up to ensure embedded Ongoing communication with HEIW to confirm their assessment of continued compliance.	<ul style="list-style-type: none"> - All the trainees have an educational supervisor and clinical supervisor. - Named individuals provided at induction programme. - Evidence presented to Panel via Clinical Supervisor Allocation List.
7.40	RCOG	Senior Clinical Midwife Cover - Review the skills and competencies of the senior clinical midwives covering for tier 1 doctors to ensure (i) their scope of practice is clearly defined (ii) the Health Board and the individuals are protected against litigation risk for their extended roles.	16.12.19	Health Board determined	<ul style="list-style-type: none"> - Scope and practice review completed. - Competencies in place and scope of practice communicated. - New Job description presented to Panel; - No perceived risk attached to role – recognised practice in a number of Health Board areas.
7.46	RCOG	Clinical Leads/Defined Roles - Appoint clinical leads in a structure that supports the service with defined role and job descriptions and objectives to include an individual response for each of the following (i) Governance and clinical quality to include guideline updating (ii) data quality, (iii) medical staff education and training (iv) multi-disciplinary training	16.12.19	Health Board determined	<ul style="list-style-type: none"> - Clinical leads appointed within an agreed structure, these interim arrangements now need to be formalised. - All governance forums are now responsible for updating and aligning Lead consultant for Audit in place. - Women's experience midwife: lead midwife for investigating concerns raised in line with PTR. - A dedicated Data quality informatics lead in place to support the Consultant Midwife to review data inaccuracies or concerns. - Evidenced through: - Governance Structure

PROJECT WORKSTREAM: Quality of Women’s and Families’ Experience

Action Ref:	Source	Recommendation	Agreed as Completed	Follow-Up Required?	Summary of Response and/or Evidence Assessed
7.48	RCOG	<p>Utilising the Strengths of the Community Health Council – Using the strengths of CHC to (i) ensure appropriate resources to act as effective advocate (ii) make information available to families (iii) exploring provision of CHC support for women and families (iv) involvement of CHC in early implementation of new Maternity Facilities.</p>	16.12.19	Ongoing	<ul style="list-style-type: none"> - HB has worked collaboratively with CHC to ensure independent advocacy support for service users. - CHC are active participants of the engagement planning meetings and have also supporting recent engagement events. - CHC attend Maternity Improvement Board and are fully engaged. - The Maternity Improvement Director attends every other full council meeting to update on progress. - Information is provided to service users and families on the role of the CHC. - CHC had a stand at the engagement events to promote their service and engage with service users. - CHC Advocates available to support women whose clinical care is being reviewed. - CHC Chief Officer attends IMSOP Panel as participating observer.

11 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 Plan
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

N.B. This is a generic glossary which covers terms which have been or may in the future be used in the Panel's reports. Not all of the terms will necessarily have been used in this particular report.

