INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL

Cwm Taf Morgannwg University Health Board

Quarterly Progress Report

Executive Summary

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.

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.

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 Plan[2] 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.

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.

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.

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.

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.

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.

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.

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.