# INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL

## Cwm Taf Morgannwg University Health Board

**Progress Report**
**September 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

 WG41277 Digital ISBN 978-1-80082-224-5

# 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 in '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 six-monthly basis. This report, the fourth to be published to date, covers the period of April to September 2020.

By design, this report is more succinct than previous reports. It does not include detailed background information nor does it repeat, to any great extent, the analysis and conclusions contained within previous reports.

Previous reports together with other information, including the terms of reference for the Panel, can be accessed here on the Welsh Government website.

**Mick Giannasi (Chair)**

**Cath Broderick (Lay Member)**

**Alan Cameron (Obstetric Lead)**

**Christine Bell (Midwifery Lead)**

# Cwm Taf Morgannwg University Health Board
# **Independent Maternity Services Oversight Panel**

**Mick Giannasi** (Chair) is the Chair of Social Care Wales. He 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

When the Panel last reported in April 2020, it concluded that the Health Board was firmly on track to deliver against the Royal Colleges' recommendations. The Panel also believed that the Health Board was making good progress towards its longer-term ambition to create an exemplar maternity and neonatal service of which they, their staff and their communities could be proud.

There was still much to be done to achieve that ambition and certainly no room for complacency. However, the Panel's main concern at that time was whether the Health Board could consolidate and build upon its early achievements against the background of the COVID-19 pandemic and the unprecedented operational and organisational challenges which were just beginning to materialise.

Six months on, whilst COVID-19 has undoubtedly had consequences, the Panel believes that the Health Board has done **remarkably well** in difficult and challenging circumstances to **maintain focus and momentum** and in doing so has made **further incremental progress** in delivering against its maternity improvement plans.

In reaching that conclusion, the Panel has taken into account a range of evidence and information which is set out in detail in the report which follows. In summary:-

- despite pressures elsewhere in the healthcare system, the Health Board and its senior leadership have remained fully committed to the Maternity Improvement Programme with no significant reduction in the level of engagement in the oversight process;
- the internal programme management arrangements which support the Maternity Improvement Programme have been fully sustained with no noticeable loss of focus or momentum and no reduction in resources or other capacity;
- support for the Panel's Clinical Review Programme has been sustained at pre-COVID-19 levels and additional staff (including some unable to work on the front line for health and safety reasons) have been brought in on an ad-hoc basis to increase the pace of progress.

That continued commitment and sustained momentum has enabled further incremental progress against the Maternity Improvement Programme, most notably:-

- a further 12 of the 79 actions within the Maternity Improvement Plan have been delivered, bringing the total now completed to 53[1] (*see section 3*);
- two of the three outstanding 'make safe' actions identified in the Royal Colleges' report (workforce planning and guidelines) have now been addressed, leaving only one (long term cultural change) still to be fully embedded (*see section 3*);
- there has been further progression against the maturity matrices within the Integrated Performance Assessment and Assurance Framework (IPAAF) with all three domains now assessed as being in the 'RESULTS' phase (*see section 4*).

[1] *In addition to the 12 actions delivered another 6 actions were removed from the Plan as part of a consolidation exercise. Further details are included in Section 3 of the report and Appendix A.*

At the same time, there have been other developments which have strengthened the capacity and capability of the Health Board to sustain those improvements in the longer term, most notably:-

- the Maternity Improvement Team has been integrated within the maternity service, enabling a transition to a continuous improvement approach which is 'owned' by frontline staff and embedded in day to day operations (*see section 8*);
- neonatal service improvement has been incorporated within the Maternity Improvement Programme whilst joint oversight arrangements have been agreed and a baseline has been established for further improvement (*see section 5*);
- the Maternity Improvement Programme has been extended to the Princess of Wales Hospital in Bridgend[2] so that maternity and neonatal services can be developed on a consistent basis across the Health Board area (*see section 3*);
- the Maternity Improvement Plan has been remodelled into a more dynamic tool with clearer milestones and targets and a longer-term focus on continuous improvement beyond the Royal Colleges' recommendations (*see section 3*);
- although COVID-19 has prevented the full rollout of the engagement and communications programme, the Health Board has developed new ways of communicating with women through increased use of social media and virtual engagement via the My Maternity My Way forum (*see section 6*);
- solid progress has been made against the majority of the 14 actions identified as 'next steps' in the Panel's previous report (*see section 8*).

Despite that further progress, it is important to emphasise that there is still a significant amount of work to be done to fully deliver against the Royal Colleges' recommendations and the pursuit of exemplar status remains a longer term ambition. In particular:-

- a number of the Royal Colleges' recommendations remain to be delivered and whilst they are work in progress, they mostly relate to areas such as culture change and leadership capacity which will take time to effect (*see section 3*);
- there is still work to be done to fully implement plans to improve in areas such as managing concerns and complaints and the programme of work emerging from earlier engagement activities will need to be delivered (*see section 8*);
- the integration of neonatal services within the Maternity Improvement Programme, whilst an essential step forward in terms of delivering a seamless service for women and families, has added additional work and increased complexity which needs to be carefully managed (*see section 5*).

In addition, some activities (most notably the leadership development, culture change and communications training programmes) have been deferred as a direct result of the impact of COVID-19 and operational pressures have hindered progress in important areas such as managing sickness, the completion of consultant job plans and PADR compliance.

---

*[2] The Royal Colleges' review was conducted in the former Cwm Taf area and the special measures escalation arrangements apply only to the Prince Charles and Royal Glamorgan Hospitals. However, since that time, the Health Board has taken responsibility for maternity and neonatal services provided at the Princess of Wales Hospital. Whilst Princess of Wales is not in special measures, it is important that services are delivered on a consistent basis and the Health Board has agreed to work with the Panel to ensure that is achieved.*

It is also important to emphasise that despite the innovative use of virtual technology, the opportunities to engage with women and families have inevitably been constrained and some elements of choice have had to be suspended. For example, the Health Board found it necessary to close the Tirion Birthing Unit at the Royal Glamorgan Hospital in order to safely manage the impact of COVID-19 related sickness absence.

All of these things will need to be reinstated and re-energised as soon as the current situation allows because they are critical to longer term sustainable improvement. The Health Board has plans to do that but it is important that any delay is minimised as far as possible. These issues and others are reflected in the 'next steps' actions which are identified throughout the report and summarised in Section 9 as the focus for the Health Board's attention during the next reporting period.

In concluding this Executive Summary, there are two important things which the Panel would wish to emphasise; one a caveat about the progress which has been made over the last six months, the other an emerging opportunity in the next phase of the Health Board's improvement journey.

The caveat is an important one. Over the past six months, the Health Board has undoubtedly made further progress against its maternity improvement plans and in particular in delivering against the Royal Colleges' recommendations. Through its internal assurance mechanisms, it has concluded 12 more of the Royal Colleges' recommendations have been delivered and embedded in operational practice.

As previously, the Panel has systematically assessed the evidence on which the Health Board has based its decision to 'sign off' those recommendations and in general terms has been reasonably assured that those decisions are appropriate. However, given the restrictions imposed by COVID-19, the validation process has not been as robust as it would have been in other circumstances. In particular:-

- the evidence review process has been confined to the assessment of paper evidence and probing conversations with senior managers and clinicians using remote technology;
- there has been no opportunity to test out the evidence through visits to operational units and structured conversations with staff in operational settings;
- some of the monitoring arrangements on which the Panel previously relied for validation (e.g. the PALS survey of women's experience) have been suspended;
- there has been limited opportunity to triangulate the Panel's assessments with evidence and information from other sources because the on-site inspection activities of external review bodies (e.g. Audit Wales and Healthcare Inspectorate Wales) and other organisations (e.g. Health Education and Improvement Wales and the Community Health Council) have been curtailed, re-programmed or conducted remotely.

The Panel does take comfort from the fact that the Health Board's internal monitoring and assurance arrangements have been incrementally strengthened over the past eighteen months and has no specific reason to doubt the robustness of its internal assessment. However, it does mean that the level of independent assurance which can be provided is more limited than on previous occasions.

On that basis, it will be necessary in the next reporting period for the Panel to revisit some of the recommendations which have been 'signed off' as delivered in the current period to ensure that they have been and remain embedded in operational practice. That process will be built into the Panel's forward plans.

The emerging opportunity relates to the next steps in the Clinical Review Programme. With the support of the Health Board and the Welsh Government, the pace and momentum of the Clinical Review Programme has been sustained throughout the current period, despite the restrictions on travel and social contact imposed by COVID-19.

As a result, the 2016-2018 lookback exercise is now well underway and during the next reporting period, the Panel will begin writing out to the women and families involved in the first cohort (the maternal morbidity and mortality category) to share individual review findings. It is also envisaged that the Panel will produce its first public facing report summarising the key themes emerging from this category towards the end of the year.

This will undoubtedly be a difficult and potentially distressing time for the women and families involved but also for Health Board staff members. The Health Board will need to ensure that all of the necessary resources and mechanisms are in place to provide the emotional, practical and administrative support which will be required to support the process before the information is shared with women and families or released into the public domain.

Not only will the Health Board need to explain what it has done since the Royal Colleges' review to make its services safer and more effective, it will also need to demonstrate that the culture of the organisation has changed too. In particular, it will need to demonstrate that the women and families who have been most affected by its previous failings are at the forefront of its thinking and display a genuine commitment to putting things right in an open, transparent, responsive and compassionate manner.

The senior leadership of the organisation has identified this as a significant opportunity to rebuild public trust and confidence and is developing its plans accordingly. However, the Panel would encourage the Board to reassure itself that those plans are suitably comprehensive and sufficiently robust to manage what will undoubtedly be an important, but potentially difficult, step forward in its improvement journey.

**NEXT STEPS - Action 1: The Panel would encourage the Health Board to take steps to reassure itself that the plans it is currently developing to manage the clinical review feedback process are robust and comprehensive.**

## 2 COVID-19

As the Panel began to draft its previous report in March 2020, the scale and impact of the threat associated with the COVID-19 outbreak was just beginning to emerge. In the circumstances, the Panel privately questioned whether it was realistic to expect the Health Board to sustain its Maternity Improvement Programme against the background of the unprecedented operational and organisational issues which were starting to materialise. Indeed, in the early stages of the Health Board's preparations for the onset of the virus, it looked increasingly likely that the Maternity Improvement Team (MIT), which is the 'engine room' for the improvement programme, might have to be redeployed onto the front line to supplement gaps in operational cover caused by COVID-19 related sickness.

In the event, the Health Board's senior leaders maintained their nerve and the need to suspend or even curtail the programme was avoided. However, the conflicting pressures involved in making that decision should not be underestimated. The fact that the programme was not only sustained, but was also supplemented by additional staff who were unable to work on frontline duties, is testament to the determination of the Health Board and the Senior Responsible Officer (SRO) and the Director of Midwifery in particular, to finish the work which has been started in improving maternity and neonatal services. As a result, substantial further progress has been made and that is why, in its overall assessment, the Panel expresses that the Health Board has done **remarkably well** to maintain focus and momentum.

Whilst the potential impact of COVID-19 on the Maternity Improvement Programme has been mitigated to a significant degree, there have undoubtedly been some consequences. Both the Health Board and the Panel have had to adjust their working practices considerably and although remote working has been used to good effect, video conferences, telephone calls and email exchanges are no substitute for face to face contact and human interaction. This has created some administrative and logistical challenges, albeit that they have been worked through and resolved in the same spirit of cooperation which has existed between the Panel and the Health Board from the outset of the oversight process.

One of the more significant consequences of the COVID-19 restrictions has been that opportunities for the Panel and the Health Board to engage directly with women and families have been significantly constrained. The same applies to the Panel's ability to engage with staff. Alternative means of communication have been developed and these have proven beneficial in some areas, but again, they are no substitute for human interaction, particularly when dealing with such sensitive and emotive issues. It is therefore important that whilst the benefits of these alternative approaches are sustained and built upon going forward, direct engagement is resumed at the earliest opportunity.

In that regard, the Panel has created a Communications and Engagement Task and Finish Group to manage the return to 'a new normality' and an action plan has been developed in co-production with the Health Board, the Community Health Council and a small focus group of women and families to take this forward.

Although the Health Board *has* done well to mitigate the impact of COVID-19 on the Maternity Improvement Programme, there have also been some organisational and operational consequences which will have implications in the next phase of the improvement journey. The potential impact should not be underestimated.

The Panel has observed staff at all levels working tirelessly and with huge dedication and commitment to balance the competing demands of maintaining day to day operations, responding to the clinical and organisational requirements of the COVID-19 outbreak and continuing to drive forward the maternity improvement process. At some stage, those people will need to reset and 'recharge their batteries' and it is perhaps to be expected that there might be some levelling off in the pace of progress in the next reporting period. The Panel will work with the Health Board to make sure that momentum is not lost; however, a sense of realism about what might be achieved in the next period is required.

There are also a number of areas where improvement activities have been deferred as a direct result of the impact of COVID-19 and others where operational pressures have hindered, or in some cases, reversed progress. All of these things will need to be addressed in the coming weeks and months and that will consume time and organisational capacity which would otherwise have been expended in making further incremental progress against the Maternity Improvement Plan. For example:-

- key training and development activities including the leadership development, culture change and communications training programmes have been suspended;
- there have been COVID-19 related set-backs in areas such as sickness levels, PADR compliance, completion of consultant job plans and compliance with mandatory training where early performance improvements had been delivered;
- although new and innovative ways have been found to engage with women and families in the absence of direct face to face contact, the full rollout of the comprehensive 2020/23 engagement programme has inevitably been curtailed;
- some elements of the maternity service, including some which provide choice for women and families have also been reduced and in particular the Tirion Birthing Centre at the Royal Glamorgan Hospital was forced to close due to COVID-19 related sickness.

All of these things will need to be addressed as soon as the current situation allows because they are critical to longer term sustainable improvement. The Health Board is developing plans to do that and has already started to make progress. However, restoring all of the things which have been affected by COVID-19 will inevitably divert focus and energy which would otherwise have been directed towards delivering further improvements. It is also important that any delay in returning to 'normality' is minimised as far as possible to ensure that the progress which has been made in the first eighteen months of the programme is not lost.

**NEXT STEPS - Action 2: The Health Board should review the impact of COVID-19 in terms of those activities or processes which have been deferred or curtailed and take the necessary action to reinstate or re-energise them at the earliest opportunity.**

# 3 PROGRESS AGAINST THE MATERNITY IMPROVEMENT PLAN

The Maternity Improvement Plan (MIP) is central to the Health Board's improvement process. The MIP contains 79 improvement actions, 70 of which are derived directly from the Royal Colleges' recommendations and the remainder from associated reviews or actions identified by the Health Board from its own analysis. When the Panel last reported in April 2020, 41 of the 79 actions contained within the plan had been delivered whilst the rest remained work in progress.

## 3.1 FURTHER PROGRESS AGAINST THE MIP

During the current reporting period, the Panel assessed evidence provided by the Health Board and concluded that 12 more actions were completed. That brings the total now completed to 53[3]. In addition, 5 other actions signed off in previous periods were re-verified. Given that this occurred against the background of the Health Board's response to COVID-19, it represents substantial further progress.

Some of the actions which have been delivered during this period are significant steps forward in the Health Board's overall improvement journey and further strengthen the foundations of a safe and effective service which is well managed, well lead and focused on the needs of service users. In particular:-

- the work which has been done to **review and update maternity guidelines** has now been completed and there is now a robust system in place to ensure that moving forward, the revised guidelines are quality assured, regularly audited and utilised in practice on a multidisciplinary basis (*recommendation 7.2*);
- **systems for incident reporting** have been strengthened, through more effective use of the Datix, improved training and the introduction of multidisciplinary forums to engage both medical and midwifery staff in identifying, assessing and responding to adverse incidents (*recommendations 7.15*);
- similarly, the processes which are in place to ensure that **learning from serious incidents** is shared with staff at all levels in a regular and accessible format have also been reviewed and strengthened (*recommendations 7.22*);
- the **My Maternity My Way** forum has now been redeveloped and re-energised to the extent that it has now become the effective engagement forum which the Royal Colleges identified as being absent (*recommendation 7.47*);
- sufficient progress has been made in terms of the way in which the service interacts with women and families to conclude that the **model of engagement** which the Royal Colleges recommended is now largely in place and has become 'business as usual' for the maternity service (*recommendations 7.49 and 7.52*);
- the improvements identified by the Royal Colleges in terms of **consultant working methods, consultant cover, supervision of medical trainees and the development of multidisciplinary teaching programmes** have now been progressed to the extent that the Health Board now considers them to be embedded in operational practice (*recommendations 7.32 and 7.37).*

*[3] In addition to the 12 actions delivered another 6 recommendations were removed from the Plan as part of a consolidation exercise. Further details are included in Section 3 of the report and Appendix A.*

Full details of the 12 actions which have been assessed as completed during the current reporting period are set out in the table at *Appendix A*.

### 3.2 Limitation in The Level of Assurance Due to COVID-19

Although the further progress which has been made over the last six months is encouraging, it is important to emphasise that as a result of restrictions imposed by COVID-19, the process for validating the delivery of the current tranche of actions has not been as robust as it was in previous reporting periods. The reasons for that are explained in more detail in section 1 of the report and for the sake of brevity they are not repeated here. As such, the Panel will need to revisit some of the actions which have been 'signed off' as delivered in the current period to ensure that they have been embedded in operational practice.

### 3.3 Developing a Health Board Wide Approach

The Royal Colleges' review related specifically to the maternity and neonatal services provided in the former Cwm Taf University Health Board (Prince Charles and Royal Glamorgan Hospitals). However, since the report was published, there has been a change in geographical boundaries and the Health Board is now also responsible for the services based at the Princess of Wales Hospital in Bridgend.

Although the Princess of Wales Hospital is not part of the special measures arrangements, it is important that services are developed on a consistent basis across the new Heath Board area. As such, with agreement from the Welsh Government and the Health Board, the Panel has been maintaining a 'watching brief' on the provision of services at the Bridgend site.

In June 2020, a routine internal clinical audit conducted by the Health Board identified some areas for development at the Princess of Wales site and an action plan was devised to address them. Whilst the fact that the issues were identified internally was a positive indication that the Health Board is making progress, it did provide the impetus to think again about how reassurance might be provided that services are being developed consistently on a Health Board-wide basis.

As a result, in July 2020, the Health Board undertook a detailed assessment of the 41 MIP actions that had been signed off in relation to the Prince Charles and Royal Glamorgan sites in order to assess whether there was evidence to demonstrate a similar level of compliance at the Princess of Wales site. Some remedial work was identified as being required, but the overall conclusion of the exercise was that there was evidence to demonstrate that consistent standards are being delivered across the three hospital sites.

Following consultation with the Welsh Government and the Health Board, the Panel agreed that from that point forward, when reviewing evidence of delivery against the MIP, actions would only be 'signed off' if there was evidence of delivery at all three hospital sites. That is the basis on which the 12 actions signed off in the current reporting period have been assessed and as a result a baseline has now been established from which improvement can be delivered on a Health Board-wide basis going forward.

### 3.4 Progress Against The Royal Colleges' Make-Safe Actions

In its early reports, the Panel focused on assessing the progress which the Health Board was making in addressing the eleven 'make-safe' actions which were identified by the Royal Colleges as requiring immediate attention due to potential safety implications.

When the Panel last reported in April 2020, three of those actions still remained work in progress. There were legitimate reasons for that and mitigation had been put in place to ensure that the service was safe whilst the remaining work was undertaken. However, the Panel called for a concerted effort from the Health Board to resolve the outstanding actions to the point where they could be signed off as completed.

During the current reporting period, the Panel have continued to monitor progress against the three outstanding actions and an update is provided at *Appendix B*.

It will be seen that two of the outstanding make-safe actions (one relating to the review of guidelines and the other to the provision of appropriate staffing levels) have now been addressed in full whilst the third (which relates to changes in the culture of the organisation) is a longer term development need which is reflected in the Health Board's wider organisational improvement plans and picked up in a number of the actions which remain to be delivered within the MIP.

On that basis, other than maintaining a general overview as part of its ongoing monitoring arrangements, the Panel is not intending to report against the 'make safe' element of the Royal Colleges' review in future reports, unless further developments make such necessary.

### 3.5 Developing the Maternity Improvement Plan

The MIP is central to the Health Board's improvement journey and it has evolved incrementally over the past 12 months. When the Panel last reported in April 2020, it concluded that whilst the plan was much improved in terms of its format and structure, there were still opportunities to enhance it further.

The Panel is pleased to report that over the last six months, there has been a concerted effort on the part of the Health Board to strengthen the plan and it is now a more refined framework for delivering longer term continuous improvement as well as an effective tool for managing the delivery of the programme.

In particular, the latest iteration of the plan is more dynamic and allows for additional actions which emerge from the Health Board's continuous improvement work to be assimilated. It also includes more detailed actions, more specific accountabilities and clearer milestones and timescales for delivery. The plan has been rationalised to reduce overlap and duplication in the remaining actions and neonatal improvement actions have also been incorporated into the plan. A high-level overview of the revised MIP is attached at *Appendix C*.

### 3.6 Assessment of Current Position and Next Steps

Significant progress has been made against the MIP over the last six months and whilst the Health Board can be quietly satisfied with what it has achieved in terms of delivery against the MIP to this point, there is no room for complacency.

During the next reporting period, the Health Board will focus its attention on making progress against the 20 remaining actions which are summarised in the table below:-

**Figure 1***: Outstanding MIP actions as at 01.09.2020*[4]

| Safe and Effective Care | Quality of Leadership and Management | Quality of Women's and Families' Experience |
|---|---|---|
| 7.1 Ensuring data quality | 7.8 External expert facilitation | 7.53 Communications strategy |
| 7.7 Privacy and dignity | 7.17 Training for SAS staff | 7.54 Co-production |
| 7.19 Serious incident review | 7.35 Training needs analysis | 7.67 Develop strategic vision |
| 7.20 Tackling 'blame culture' | 7.39 Consultant cover (gynae) | 7.70 Service change |
| 7.31 Long term birth planning | 7.42 Values and behaviours | |
| 7.51 Complaints and concerns | 7.44 Clinical leadership training | |
| 7.63 Board assurance | 7.45 Clinical mentorship | |
| | 7.56 Communications training | |
| | 7.69 Talent management | |

All of the outstanding actions are currently work in progress and substantial headway has been made against a number of them. However, it is clear from this list that there is still a significant amount of work to be done to deliver the whole plan and in particular to address all of the 70 recommendations contained within the Royal Colleges' report. It will also be seen that most of the remaining actions relate to more complex, longer-term issues (including organisational culture, leadership capacity, longer term plans and strategies) which will take time to resolve to the extent that they can be considered to have been fully delivered.

Over the past six months, the MIP has transitioned from a static plan based on the delivery of a list of external recommendations to one which is now more dynamic and increasingly driven by a longer term, continuous improvement process embedded within the day to day operations of the service. Whilst the Royal Colleges' recommendations will remain visible and central to process, the MIP will constantly evolve through time as new actions and improvement opportunities emerge.

In light of these developments, it would be timely for the Panel and the Health Board to jointly review the existing performance monitoring arrangements to ensure that they reflect the adjustments which have been made to the MIP.

**NEXT STEPS - Action 3: In light of recent developments within the MIP, the Health Board and the Panel should jointly review the arrangements for monitoring, evaluating and reporting progress.**

[4] *A full list of the 70 recommendations can be found in the Royal Colleges' report which can be accessed here.*

# 4 ASSESSMENT OF OVERALL PROGRESS AGAINST THE IPAAF

The Integrated Performance Assessment and Assurance Framework (IPAAF) has been developed jointly by the Heath Board and the Panel to enable improvements in maternity and neonatal services to be monitored, assessed and reported in a way that is easy to understand and relatively free from statistics and technical jargon.

A more detailed explanation of the IPAAF methodology and the process by which it has been developed can be found in the Panel's earlier reports. A concise summary can be found in the April 2020 report which can be accessed here.

## 4.1 THE IPAAF – A BRIEF DESCRIPTION

The IPAAF triangulates information from a range of sources to provide a comprehensive assessment of how the service is performing across a number of different domains. It uses a mixture of quantitative and qualitative information (including evidence of delivery against the actions within the MIP, a range of performance metrics and feedback from service users) to create a rich picture of how the service is performing.

Although the IPAAF methodology is necessarily complex, a set of maturity matrices have been developed to provide a simple way for service users and other stakeholders to understand the extent to which the Health Board's maternity and neonatal services are assessed as:-

- safe and effective;
- well led and well managed;
- focused on the quality of women and families experience.

The maturity matrices are also designed to provide an understanding of how those assessments have changed over time and on that basis, to what extent services are maturing - or not as the case may be. The maturity matrices describe five levels of progress using a series of narrative descriptors, as follows:-

**Figure 2**: *Maturity Matrix Progress Levels*

| Criteria | Definition |
|---|---|
| **1 Basic Level** Principle accepted and commitment to action | Health Board is aware of the requirement but is unable to demonstrate meeting it and/or cannot evidence clear plans or approaches to meet the criteria. |
| **2 Early Progress** Early Progress in development | The Health Board recognises what is required for the criteria. The Health Board is able to evidence being able to meet *some* of the criteria but cannot evidence being able to meet all aspects in full. The Health Board plans to meet all the criteria in full |
| **3 Results** Initial achievements realised | The Health Board meets some of the criteria, inline with its agreed milestones, it has clear and credible plans to continually and sustainably improve service provision. |
| **4 Maturity** Results consistently achieved | The Health Board meets all the criteria to a high standard, can evidence many examples of good practice against the criteria which are routinely shared and adopted by others. |
| **5 Exemplar** Others learning from our consistent achievements | The Health Board's excels at all criteria, service provision and patient experience is excellent. The Health Board is leading the strategic agenda through the implementation of innovative practice that is shared with other Health Boards and beyond the organisation to others, enabling realisation of long term sustainability. |

Separate descriptors have been developed for each of the three IPAAF performance domains (i.e. Safe and Effective Care, Quality of Women's and Families' Experience and Quality of Leadership and Management).

When the Panel last reported in April 2020, it concluded that whilst the IPAAF would still benefit from some further refinement, it did provide a sound basis for regular reporting of the progress which the Health Board was making in its maternity improvement journey. As a result, the Health Board conducted an initial assessment against the maturity matrices to create a baseline against which further improvement could be benchmarked.

At that time, the Health Board concluded that it was making **'Early Progress'** in all three of the performance domains and the Panel agreed with that assessment.

### 4.2 Developments in the IPAAF During the Current Reporting Period

Over the past six months, the Health Board has made a series of incremental improvements to the IPAAF methodology. This includes, for example:-

- some strengthening of the assessment framework to bring it into line with the process being developed at corporate level to support the wider targeted intervention process;
- a more granular approach to the assessment of the impact of individual improvement actions on the overall assessment outcome;
- a self-assessment tool which identifies the evidence available from a range of sources against each of the maturity matrix descriptors and progress levels;
- improvements in the analysis of quantitative data to identify trends over time and the reasons which might be driving those trends.

In the Panel's view, these improvements have strengthened the robustness of the assessment framework and add weight to the outcomes.

### 4.3 Current Assessment against the IPAAF Maturity Matrix

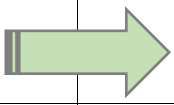
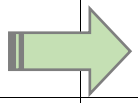
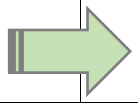
During August 2020, the Health Board conducted its second self-assessment against the IPAAF maturity matrices. The self-assessment report was presented to the Maternity Improvement Board (MIB) for approval on 18 August and presented to the Health Board's Quality and Safety Committee to be ratified on 03 September 2020.

On the basis of the self-assessment, the Health Board has concluded that the current level of maturity against the three domains is as follows:-

- **Safe and Effective Care** is now firmly in the '**Results'** phase with some aspects of the service approaching 'Maturity';
- **Quality of Women's Experience** is also in the **'Results'** phase although some aspects of the service remain in 'Early Progress';
- **Quality of Leadership and Management** is also on balance in the **'Results'** phase although some aspects of the service remain in 'Early Progress'.

These assessments are shown in the figure below. The arrow provides an indication of progress since the last assessment was conducted in April 2020.

**Figure 3**: *Maturity Assessment – 28 August 2020*

| | LEVEL OF MATURITY | | | | |
|---|---|---|---|---|---|
| | **Basic** | **Early Progress** | **Results** | **Maturity** | **Exemplar** |
| **Safe and Effective Care** | |  | | | |
| **Quality of Women's Experience** | |  | | | |
| **Quality of Leadership and Management** | |  | | | |

The Panel has reviewed the Health Board's rationale for those assessments and whilst it might have reached different judgments about the grading of a small number of individual elements within the framework, it agrees with the overall conclusions.

It is important to emphasise that **'Results'** does not mean that the all of the necessary work is completed or that the service is performing fully to expectations. What it does mean is that the Health Board is making steady progress across all three of the performance domains and whilst there is much still to be done to achieve the standards it aspires to, there are credible plans in place and it remains broadly on track to achieve them.

### 4.4 Development of the IPAAF – Next Steps

The IPAAF has developed significantly over the past twelve months to the point where it now provides an effective mechanism for monitoring, assessing and reporting the progress. However, it was always intended that the framework would evolve over time and in discussion with the Health Board, a number of areas have been identified where the framework could be strengthened further. This includes, for example, aligning the framework more closely to the Health Board's corporate performance framework, providing more explicit descriptors for the maturity and exemplar phases, making better use of quantitative data to inform the assessment process and reflecting the transition of the MIP to a continuous improvement process. Given that the framework has completed two cycles, it would seem to make sense to take stock and identify how the framework could be strengthened over the next reporting period.

**NEXT STEPS - Action 4: The Panel believes that it would be helpful during the next reporting period for the Health Board to organise a further multidisciplinary workshop to review the current IPAAF and agree the next phase of its development.**

# 5 INTEGRATION OF NEONATAL SERVICE IMPROVEMENT

The Health Board and the Panel have agreed that the integration of maternity and neonatal provision is an important prerequisite for a safe and effective end-to-end service which focuses on the needs of women and their babies. When the Panel reported in April 2020, it identified that more needed to be done to achieve that integration and called for an increased focus on neonatal issues moving forward.

## 5.1 INTEGRATING NEONATAL SERVICES

The Health Board has taken decisive steps to assimilate neonatal service improvement into the overall Maternity Improvement Programme, including:-

- increased oversight of neonatal issues through the MIB;
- an overarching leadership role for the Director of Midwifery;
- the inclusion of a specialist neonatal nurse within the MIT;
- routine involvement of the neonatal senior leadership team in Panel meetings;
- the Medical Director increasingly playing a coordinating role;
- early action to align key processes like clinical audit and clinical governance.

In terms of programme management, whilst the neonatal component will remain clearly visible and identifiable, neonatal improvement actions have been integrated into the MIP and reflected in the maturity matrices which form part of the IPAAF.

Whilst there is much that can be achieved through a more integrated approach to service improvement, it has become increasingly clear to the Panel and to the Health Board that the longer term solution might lie in some form of structural change. Maternity and neonatal services are currently in different parts of the organisational structure and the Health Board is actively considering how this might be addressed through the revised operating framework which is currently being rolled out on an organisation-wide basis.

This is a complex issue which has links to the South Wales Programme and wider issues around consultant availability and the provision of paediatric services at the Royal Glamorgan Hospital. However, some clarity is now needed and the Panel would urge the Health Board to identify a way forward at the earliest opportunity.

**NEXT STEPS – Action 5: The Health Board should identify a longer term structural solution which would bring about closer integration of maternity and neonatal services.**

## 5.2 NEONATAL SERVICES IMPROVEMENT – CURRENT POSITION

As a result of the measures which have been put in place, both the Panel and the Health Board now have a far better oversight of neonatal issues. In particular, a baseline has been established to identify firstly, what has been delivered so far against the Royal Colleges' recommendations and secondly, what more needs to be done going forward.

A review conducted jointly by the Panel and the Health Board identified that 30 of the 70 recommendations contained with the Royal Colleges' report required some form of action from a neonatal perspective. Of those, 7 related specifically to the neonatal service and 23 were more generic actions which applied equally to neonatal and maternity. In response, a self-assessment exercise has been undertaken by the neonatal senior management team to identify the progress which has been made in delivering against the 30 recommendations since April 2019. The assessment was informed by the findings of the peer review undertaken by the Maternity and Neonatal Network in September 2019.

The self-assessment concluded that of the 30 recommendations, 9 had been fully delivered, 2 had not been delivered and were an immediate priority whilst 17 were work in progress. The two remaining recommendations related to the reconfiguration of the service in March 2019 and were therefore no longer relevant. From this baseline, it is clear that whilst some early progress has been made, a significant amount of work is still required to address all of the Royal Colleges' neonatal service related recommendations.

### 5.3 Oversight of Neonatal Improvement – A shared Approach

In consultation with the Health Board, the Panel has agreed that 16 of the 30 neonatal recommendations are critical to the delivery of a seamless end-to-end service. This includes recommendations relating to key issues such as clinical audit, guidelines and protocols, induction of medical staff, learning from serious incidents, engagement with women and families' guidelines and bereavement services. These recommendations will be subject to direct oversight by the Panel as an integral part of the Maternity Improvement Programme.

The remainder of the recommendations, which relate to more generic issues will be monitored and assessed by the Health Board through the MIB. Those recommendations will remain visible and accessible within the MIB process and the Panel will draw its assurance from the systematic approach put in place by the Health Board, rather than by directly assessing the evidence for these particular recommendations itself.

A flexible approach will be adopted and direct oversight of specific recommendations may revert back to the Panel if deemed necessary. This flexibility will be particularly important as the findings from the independent Clinical Review Programme emerge to ensure that the external oversight process covers all of the issues which are essential to the provision of a safe, high quality, person-centred service for women and their babies.

The decision to divide up the oversight of neonatal improvements in this way recognises that the Health Board's internal governance and assurance processes have developed significantly since the oversight process first commenced. There is now increasing confidence in the capability of the Health Board to effectively oversee delivery of its improvement plans and/or escalate as necessary. That said, the Panel reserves the right to provide constructive challenge or to draw specific recommendations back into the external oversight process should this be deemed necessary.

# 6 ENGAGEMENT WITH WOMEN AND FAMILIES

When the Panel reported in April 2020, it concluded that the Health Board was building steadily on the early progress it had made in engaging more effectively with the women and families who use its services as well as with its wider communities.

The Panel has reported extensively on those early developments in its earlier reports and they are not repeated here, other than to say that it is particularly encouraging to see the skills, knowledge and experience which have been gained over the past eighteen months now being reflected in the 2020/23 Engagement Strategy which has recently been approved by the MIB. It is also encouraging to see the methods being used in maternity services increasingly influencing the Health Board's wider approach to communication and engagement.

## 6.1 RECENT DEVELOPMENTS

The Health Board has continued to build upon its early successes during the current reporting period despite the constraints imposed by COVID-19. It has also begun to make progress on perhaps the most important part of the engagement process, that of using the feedback from service users and communities to influence service change and quality improvement. The following developments are worthy of note:-

- **Real Time Engagement** - The regular Patient Advice and Liaison Service (PALS) 'real time' discussions with women and families using maternity services were suspended due to COVID-19 but are now being reinstated and expanded into antenatal groups and the community. In the absence of the PALS feedback, the Health Board has rapidly expanded its use of social media to engage more extensively in online conversations with women about their maternity experience. The Panel's engagement lead routinely monitors these channels and has been encouraged by the overwhelming positive feedback from women and the rapid response to suggestions for improvement.

- **My Maternity My Way** - The My Maternity My Way (MMMW) forum has continued to evolve. The Lay Chair has brought new impetus and the Women's Experience and Consultant Midwives who support the forum have provided considerable energy to its work programme. Women and family members contributing to MMMW meetings have been closely involved in designing the posters and leaflets to promote the forum. Women taking part in MMMW meetings are sharing their stories regularly, thereby highlighting areas of good practice and those experiences where different approaches and better communication would have made a difference. These experiences are driving the agenda for the MMMW forum and highlighting areas where change is needed. Importantly, women's stories are now being used as a training tool with plans to create video records well advanced. The MMMW meeting has a standing agenda item providing members with oversight of concerns, complaints and compliments. This is a positive step forward in triangulating engagement, feedback, learning and actions.

- **15 Steps Programme** - The Panel is particularly pleased to see that the 15 Steps Programme, which is a variation on the mystery shopping observational approach to understanding what service users and carers experience when they first arrive in a healthcare setting, is now a core part of the evaluation process.

- **Virtual Engagement** - The COVID-19 outbreak has accelerated innovation and resulted in the development of new ways to reach out to women and families and to hear about their experience of using maternity and neonatal services. MMMW meetings have taken place more frequently and feedback indicates that women and families find this approach more accessible.

- **Using Social Media** - The Health Board's 'Bump Talk' Facebook page was already a vibrant forum for women using maternity services. It provides a widely and readily accessible medium to share questions, experiences and views. As a result of the restrictions on face to face contact resulting from COVID-19, the use of 'Bump Talk' has increased. The Health Board has responded proactively by posting videos, posters and other information on Bump Talk and other social media channels to explain how services have been adapted.

- **Virtual Tours** - In response to feedback from women unable to visit the maternity units in person due to COVID-19, virtual video tours have been created.

These innovations, developed under pressurised conditions in the immediate aftermath of COVID-19 outbreak, demonstrate how far the Health Board has travelled in engagement terms since the publication of the Royal Colleges' report. The Panel is encouraged to see innovation increasing and is confident that the range and scope of the Health Board's engagement approach will continue to evolve.

### 6.2 Making a Difference – The Impact of Engagement

The thematic analysis of the feedback from the 2019/20 community engagement events has now been completed. The emerging themes have been triangulated with information from other sources, including the PALS real time surveys, social media feedback captured during the past year and themes and issues emerging from complaints and concerns.

These themes have become the drivers for the 2020/23 work programme within the new Maternity Engagement Plan. This focuses on four key areas, namely:-

- infant feeding (information, choices and support);
- provision and access to perinatal mental health services;
- enabling women to understand the reasons for their maternity care;
- facilitating partner's inclusion in the maternity pathway.

### 6.3 Involving Women and Families

With the support of advocates from the Community Health Council, the Health Board and the Panel are working in co-production with some of the women and families who have been most affected by the issues identified in the Royal Colleges' report.

In particular, a small group of women and families have been helping to shape the feedback process which is a vital part of the Panel's Clinical Review Programme.

The women and families have provided valuable insights into how others in similar situations might want to receive information about their individual clinical reviews, about how they might want to be supported through the process, as well as how they may wish to be involved in the feedback process. These insights have influenced the arrangements which the Panel and Health Board are now putting in place.

### 6.4 NEXT STEPS

The Panel believes that there is a growing understanding within the Health Board of the need for a systematic engagement process which is firmly embedded within the clinical governance framework. In the next reporting period, the Panel would hope to see significant progress in four key areas which are central to this approach:-

- The Health Board is developing an Engagement Cycle process map which together with the Women and Families' Forum and the MMMW forum will be central to its monitoring, reporting, prioritisation and decision-making processes.

  **NEXT STEPS - Action 6: The Panel believes that the Engagement Cycle process map is an important development which should be progressed at the earliest opportunity.**

- The Health Board has previously decided that it will develop a maternity-specific Patient Reported Experience Measures (PREMS) tool that would secure regular feedback from women and families about the care they received. However, this has been delayed due to the COVID-19 response.

  **NEXT STEPS - Action 7: The Panel believes that PREMS is an important development which the Health Board should progress at the earliest opportunity.**

- Progress continues to be made in terms of responding within more appropriate timescales to complaints and concerns and additional resources have been put in place to support investigation and action planning. However, the emerging themes still reflect issue highlighted in the Royal Colleges' review.

  **NEXT STEPS – Action 8: The Panel will continue to monitor how the Health Board responds to recurrent themes from complaints and concerns.**

- The Health Board has identified the need to enhance the way in which it communicates the improvements which have been made in maternity services and has allocated resources to undertake the necessary development work.

  **NEXT STEPS - Action 9: The Health Board should develop a process for communicating the progress of its maternity services improvement work at the earliest opportunity.**

# 7 INDEPENDENT CLINICAL REVIEW PROGRAMME

When the Panel last reported in April 2020, the first phase of the Clinical Review Programme was well underway. The independent teams undertaking the individual clinical reviews had started work and a Project Group had been established to manage the overall programme. Since then, the arrangements for the overall management of the programme have been strengthened and the original Project Group has been superseded by two functions:-

- a Project Board which is responsible for overseeing the programme and comprises the Panel's Obstetric, Midwifery and Engagement Leads together with representatives from the Welsh Government and the NHS Wales Delivery Unit;
- an Operations Group which is responsible for ensuring the smooth running of the case reviews and comprises the Panel's Obstetric and Midwifery leads and representatives from the Health Board and the Community Health Council.

COVID-19 has presented some new challenges and it has been necessary to adapt the clinical review process to optimise the use of remote technology. The teams have adapted well to working in a virtual environment and with the continued support of the Health Board, good progress has been made. This is summarised below.

## 7.1 CLINICAL REVIEW PROGRAMME – CURRENT STATUS

A detailed explanation of the clinical review programme is set out in the Panel's Clinical Review Strategy which can be accessed here.

The Panel's clinical review work is currently focused on around 160[5] episodes of care[6] provided by the Health Board between January 2016 and September 2018[7]. This includes the 43 incidents which were originally identified in the Royal Colleges' report. The episodes of care have been sub-divided into three cohorts which are set out in the table below in the order in which the reviews are being undertaken.

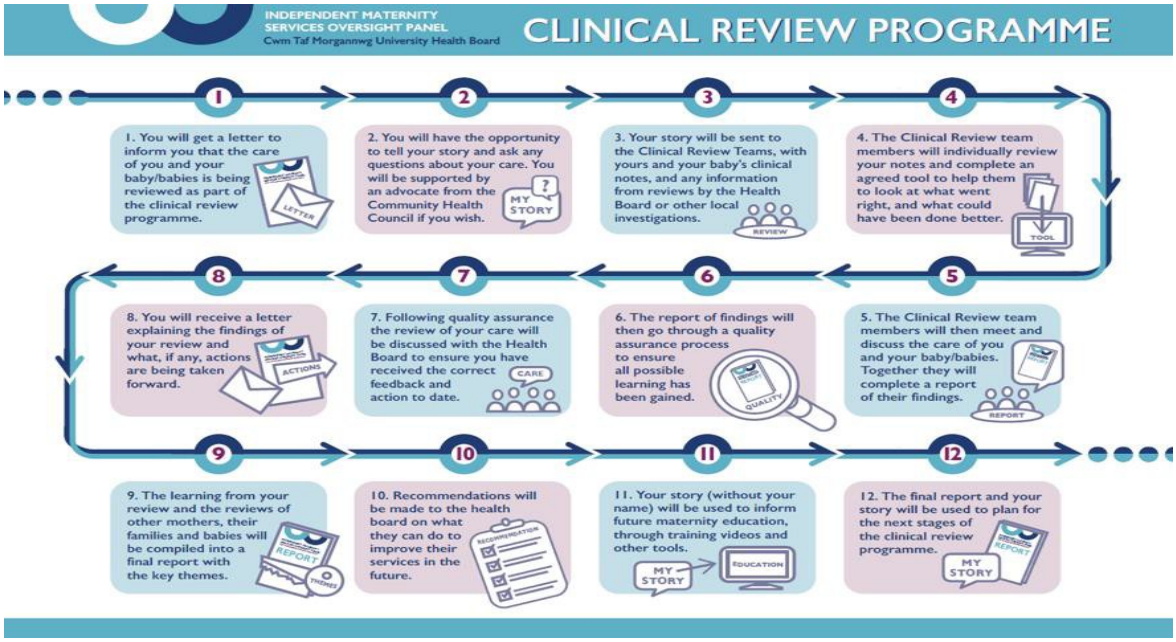
| CATEGORY | DESCRIPTION |
|---|---|
| 1. Maternal mortality and morbidity | Care of mothers, including those who may have needed admission to the intensive care unit (ICU) |
| 2. Stillbirths | Babies who sadly were stillborn |
| 3. Neonatal mortality and morbidity | Babies who sadly died following birth or needed specialist care |

All the women whose care is being reviewed have now been contacted to advise them that their review has or is about to commence.

*[5] The Panel's previous report referred to around 150 episodes of care being reviewed, although it was emphasised that the number was likely to change as new information became available.*
*[6] The increased estimate of around 160 reflects the inclusion of a number of self-referral cases which met the criteria for clinical review and a decision to include more than one pregnancy for some women.*
*[7] A small number of the self-referrals cases which have been included pre-date January 2016.*

A pathway has been developed to explain how the clinical review process will work. This is shown in Figure 4 below and a larger version is attached at *Appendix D*.

**Figure 4***: Clinical Review Pathway*




## 7.2 Quality Assurance

The quality assurance (QA) process (Step 7 on the pathway) has been put in place to ensure consistency across the reviews. The QA Panel meets on a regular basis to assess cases which have been completed by the clinical review teams. This enables learning to be identified and fed back to the Health Board so that the need for improvement action can be assessed and answers provided to any questions raised in the patient stories provided to the Panel. The QA process is detailed and thorough and it is an essential step in ensuring that the letters which will be sent to women and families explaining the outcomes of their review are accurate and complete. This part of the process is taking longer than anticipated but it remains important that it is absolutely right before any feedback letters are sent to women and families.

## 7.3 Timeframes for Completion

Given the complexity of the process, it is not possible, at this stage, to make accurate predictions regarding the timescale for the completion of the full Clinical Review Programme or to say precisely when women and families will be made aware of the findings of their individual clinical review. However, as a broad indication of progress, the following table indicates the current step on the clinical review pathway for each of the three cohorts.

| CATEGORY | CURRENT STATUS |
|---|---|
| 1. Maternal mortality and morbidity | Step 7 |
| 2. Stillbirths | Steps 5/6 |
| 3. Neonatal mortality and morbidity | Steps 3/4/5 |

On that basis, it is anticipated that the Panel will begin writing out to the women and families involved in the maternal mortality and morbidity category in the late Autumn to make them aware of their findings. It is also envisaged that towards the end of 2020, the Panel will produce its first 'end-stage' report which will summarise the key themes emerging from the maternal mortality and morbidity category.

### 7.4 SELF-REFERRALS

The Clinical Review Programme includes a process for reviewing cases which have been self-referred by women and their families. This process was explained in some detail in the Panel's previous report. A pathway has been prepared to explain the self-referral process to women and families and is attached at *Appendix E*.

In line with that process, the triage element has now been completed and the Health Board has made contact with all of the families who have self-referred to involve them in determining an appropriate resolution. The Health Board is currently developing detailed timelines for each of the self-referral cases in order for them to be reviewed by the Panel. There are currently 39 self-referral cases being assessed.

It was anticipated that the timelines for each of the self-referral cases would be presented to the Panel by the end of July 2020. However, the level of detail required has been greater than anticipated and the most recent trajectory produced by the Health Board indicates that the work will be completed and presented to the Panel in the first week of October. At that stage, letters will be sent to women and families advising them of the outcome of their self-referral review and offering the opportunity to meet with the Health Board if desired.

### 7.5 POST-OCTOBER 2018 SERIOUS INCIDENTS

As part of the Clinical Review Programme, the Panel is dip-sampling the quality of serious incident reviews conducted by the Health Board since October 2018. A structured QA process has been developed and this was outlined in the Panel's previous report.

Nine serious incident reviews have been quality assured to date but the Panel concluded that only two had been completed to an acceptable standard. In May 2020, the Panel met with the Health Board and recommended a review of the processes currently in place to ensure that serious incident investigations are completed to a reasonable standard and that women and their families are engaged. As a result, the Health Board is undertaking a significant piece of work to review both its processes and a backlog of serious incidents.

The Panel has agreed to resume its quality assurance role when it receives assurance from the Health Board that its processes are fit for purpose and that consistent standards of serious incident investigation are being routinely achieved.

**NEXT STEPS - Action 10: The Health Board should complete its review of the systems and process currently in place for ensuring the quality and consistency of serious incident reviews in order for the Panel to resume its post-October 2018 quality assurance work at the earliest opportunity.**

# 8 HEALTH BOARD RESPONSE

The Health Board's response to the Royal Colleges' review has been explored in some detail in the Panel's previous reports and is not repeated here.

However, it is perhaps important to emphasise that eighteen months on, the improvement framework which has been put in place through the Maternity Improvement Board (MIB), the Maternity Improvement Team (MIT) and the three Project Boards has incrementally evolved and continues to work well.

Over the past six months, against the background of the COVID-19 outbreak, the Health Board has worked collaboratively with the Panel to continue to drive forward the Maternity Improvement Programme. Despite all of the other challenges and issues which the organisation has faced during this difficult period, the genuine sense of ownership and commitment at Chair, CEO and Board level has remained solid and the Senior Responsible Officer (SRO) and the Director of Midwifery in particular, have continued to work constructively with the Panel in a mutually supportive but challenging atmosphere.

At the same time, the internal programme management arrangements have been fully sustained with no reduction in resources or other capacity. Support for the Clinical Review Programme has been sustained at pre-COVID levels and additional staff (including some unable to work on the frontline for health and safety reasons) have been brought in on an ad-hoc basis to increase the pace of progress.

All of that has meant that there has been no loss of momentum or focus in either the oversight process or the Maternity Improvement Programme and as a result, significant further progress has been made against the MIP.

## 8.1 DEVELOPMENTS DURING THE CURRENT PERIOD

The most significant development which has occurred during the current reporting period has been the transition of the MIT from what was an offset programme management function to what is now a service led quality improvement function.

When the Panel last reported in April 2020, the Maternity Improvement Director had been successful in securing a permanent post within the Health Board and the Director of Midwifery had recently taken up post. On that basis, the SRO took the opportunity to review the existing arrangements. As a result, he decided not to replace the Maternity Improvement Director and appointed the Director of Midwifery to take on the role of Programme Director in addition to her head of service function.

Whilst the revised arrangements were clearly a matter for the Health Board, the Panel was consulted and was able to influence the format and structure of the revised arrangements to ensure that there was still sufficient capacity and capability within the team to support the clinical review and oversight processes.

There was a slight lull in the initial stages whilst new staff were recruited and there were some minor teething problems. However, since the revised arrangements have become embedded, they have been more effective and there have been some significant benefits, not least the fact that responsibility for the improvement programme and the delivery of the service are now vested in one individual.

Whilst that does present some challenges for the Director of Midwifery in terms of managing workload, the benefits can be seen in quicker decisions, greater clarity and increased reach and impact. It has also meant that when additional resources have been available, further capacity has been provided in order to increase pace.

Perhaps the most important development though is that this has enabled the development of a continuous improvement ethos which is embedded in operational delivery and the improvement process is increasingly being owned by the staff who deliver the service. That is a significant step forward and one which should increasingly pay dividends as the improvement programme moves forward.

### 8.2 Progress Against the 'Next Steps' Actions

In Section 9 of its April 2020 progress report, the Panel identified a number of areas where it expected to see the Health Board make progress during the current period.

These 'Next Steps' actions are set out in the table at *Appendix F,* together with a brief assessment of the current position against each.

It will be seen that substantial progress has been made against a number of those actions and where further work remains to be done, this is either reflected with the MIP or represented by a new action being created for the forthcoming period.

### 8.3 Appointment of the New Chief Executive Officer

The Panel has enjoyed a constructive relationship with the Interim Chief Executive and her personal support for the Maternity Improvement Programme and the Independent oversight process in particular has been a significant factor in the progress which has been made. The Panel looks forward to meeting the recently appointed Chief Executive at the earliest opportunity in the hope that a similar relationship can be developed going forward.

# 9 CONCLUSIONS, NEXT STEPS AND RECOMMENDATIONS

## 9.1 SUMMARY OF CURRENT POSITION

When the Panel last reported in April 2020, it concluded that the Health Board was firmly on track to deliver against the Royal Colleges' recommendations and was making good progress against its longer term ambition to create an exemplar maternity and neonatal service.

Over the past six months, despite the unprecedented challenges created by COVID-19, the Health Board has managed to maintain its earlier momentum and has made further incremental progress against its maternity improvement plans. This includes the delivery of another significant tranche of the Royal Colleges' recommendations which means that 50 of the 70 recommendations have now been delivered.

As previously, the Panel has systematically assessed the evidence on which the Health Board has based its decision to 'sign off' those recommendations and in general terms has been reasonably assured that those decisions are appropriate. However, given the restrictions imposed by COVID-19, the validation process has not been as robust as it would have been in other circumstances. As such, it will be necessary to revisit some of these recommendations in the next period to ensure that they remain embedded in practice.

As a result of that further progress and other developments, the Health Board has progressed to the 'Results' phase in all three of the IPAAF performance domains. The fact that this has been achieved against the background of COVID-19, reflects great credit on staff at all levels and is testament to the commitment and determination of the Health Board and its senior leadership team to improve its maternity and neonatal services.

At the same time, there have been a number of other developments which have strengthened the ability of the Health Board to maintain those improvements in the longer term, not least the transition of the Maternity Improvement Programme to a service led process, the redevelopment of the Maternity Improvement Plan to reflect a revised continuous improvements ethos and the measures which have been put in place to bring about the closer integration of maternity and neonatal services.

Despite that further progress, there remains a significant amount of work to be done to fully deliver against the Royal Colleges' recommendations. Most of the remaining actions now relate to more complex, longer-term issues (including organisational culture, leadership capacity, longer term plans and strategies) which will take time and continued focus to resolve to the extent that they can be regarded as delivered.

In addition, COVID-19 has had a range of adverse consequences, most notably in terms of improvement activities which have been deferred or services which have been suspended or curtailed. All of these things will need to be addressed in the coming weeks and months and that will consume time and organisational capacity which would otherwise have been expended in making further incremental progress against the Maternity Improvement Plan.

One of the areas which has been curtailed is the roll out of the Health Board's 2020/23 Engagement Strategy. However, whilst face to face activities have been constrained, the maternity service has developed a range of new and innovative ways to engage in a two-way exchange with women who use the service.

In the meantime, the Panel's independent clinical review process is progressing well and the first phase (the 2016-18 look back exercise) is now well underway. It is anticipated that the Panel will begin writing out to the women involved in the first cohort (the maternal morbidity and mortality category) during the next reporting period and will produce its first 'end-phase' report towards the end of the 2020.

This will undoubtedly be a difficult and potentially distressing time for the women and families involved but also for Health Board staff. The Health Board will need to ensure that all the of the necessary resources and mechanisms are in place to provide the emotional, practical and administrative support which will be required to support the process, before the information is shared with women and families or released into the public domain.

The senior leadership of the organisation has identified this as a significant opportunity to rebuild public trust and confidence and is developing its plans accordingly. However, the Panel have encouraged the Board to reassure itself that those plans are suitably comprehensive and sufficiently robust to manage what will undoubtedly be an important, but potentially difficult, step in its improvement journey.

Whilst there is cause for optimism, the next six months will be no less challenging for the Health Board than the previous eighteen and there is a new and potentially difficult issue on the horizon which will need to be carefully and sensitively handled.

### 9.2 NEXT STEPS

At various points in the report, the Panel has identified 'Next Steps' actions which will provide a joint focus for the Panel and the Health Board during the next period. These are set out below for ease of reference:-

- **ACTION 1: Clinical Review Feedback** - The Panel would encourage the Health Board to take steps to reassure itself that the plans it is currently developing to manage the clinical review feedback process are robust and comprehensive.

- **ACTION 2: Impact of COVID-19** - The Health Board should review the impact of COVID-19 in terms of those activities or processes which have been deferred or curtailed and take the necessary action to reinstate or re-energise them at the earliest opportunity.

- **ACTION 3: Maternity Improvement Plan** - In light of recent developments within the MIP, the Health Board and the Panel should jointly review the arrangements for monitoring, evaluating and reporting progress.

- **ACTION 4: Further Development of the IPAAF** - The Panel believes that it would be helpful during the next reporting period for the Health Board to organise a further multidisciplinary workshop to review the current IPAAF and agree the next phase of its development.

- **ACTION 5: Service Integration** - The Health Board should identify a longer term structural solution which would bring about the closer integration of maternity and neonatal services.

- **ACTION 6: Engagement Cycle** - The Panel believes that the Engagement Cycle process map is an important development which should be progressed at the earliest opportunity.

- **ACTION 7: Development of PREMS** - The Panel believes that PREMS is an important development which the Health Board should progress at the earliest opportunity**.**

- **ACTION 8: Complaints and Concerns** - The Panel will continue to monitor how the Health Board responds to recurrent themes from complaints and concerns.

- **ACTION 9: Communicating Progress** - The Health Board should develop a process for communicating the progress of its maternity services improvement work at the earliest opportunity.

- **ACTION 10: Post-October 2018 Serious Incidents** - The Health Board should complete its review of the systems and process currently in place for ensuring the quality and consistency of serious incident reviews at the earliest opportunity in order for the Panel to resume its post-October 2018 quality assurance work.

These actions will be monitored through the established assurance process and progress will be reported upon when the Panel produces its next report.

### 9.3 RECOMMENDATIONS

In view of the progress which has and continues to be 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 specific recommendations for the Health Board or the Minister to consider at this stage.

## 10 LIST OF APPENDICES

*Appendix A:* Schedule of Completed Royal Colleges' Recommendations
*Appendix B:* Progress Against Royal Colleges' 'Make Safe' Actions
*Appendix C:* High Level Maternity Improvement Plan
*Appendix D:* Clinical Review Pathway
*Appendix E:* Self-Referral Pathway
*Appendix F:* Health Board Progress Against 'Next Steps' Actions

**Schedule of Actions Recorded as Completed (April to September 2020)**

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

During earlier reporting periods (October 2019 to March 2020), 41 of the 79 actions were verified as completed. Details of those actions can be found in the Panel's progress reports published in January 2020 and April 2020.

In the current reporting period (April to September 2020), the Panel has assessed supporting evidence provided by the Health Board and agreed that a further 12 actions had been progressed and were ready for 'sign off' as completed. In addition, 5 other actions which were signed off in previous periods were re-validated. That brings the total number of actions now completed at the end of September 2020 to 53.

In addition to the 12 actions which have been 'signed off' as completed during this period, 6 other actions have been removed from the Plan with the agreement of the Panel in order to reduce duplication and unnecessary overlap within the MIP. That means that 20 actions remain to be delivered and all of those are work in progress in varying stages of completion.

Of the 6 actions removed from the Plan, one is no longer relevant due to the changes in the operating model and the other 5 relate to work being undertaken by the NHS Delivery Unit which is being monitored separately and is not therefore, within the Panel's remit to sign off.

Details of the 12 actions which were newly verified as 'signed off', the 5 actions which have been re-verified and the 6 which have been removed from the Plan are set out in the table below, grouped by the three project workstreams (which align with the three performance domains with the IPAAF). One of the recommendations (7.68) was an action which was being managed by the Health Board. For the sake of convenience this has been included in the Quality of Leadership and Management domain.

In previous reports, a summary of the evidence on which the decision to 'sign off' the action as completed was included within the table. That made the document overly complicated and difficult to present. On this occasion, that summary has not been included. However, it is important to emphasise that there is a comprehensive audit trail which provides clear links to the evidence on which the decision is based.

It is important to emphasise that as a result of restrictions imposed by COVID-19, the process for validating the delivery of the current tranche of actions has not been as robust as it was in previous reporting periods. The reasons for that are explained in more detail in the body of the report and for the sake of brevity they are not repeated here. However, it does mean that it will be necessary in the next reporting period for the Panel to revisit some of the actions which have been 'signed off' as delivered in the current period to ensure that they have been and remain embedded in operational practice. Where this is the case, it is referenced in the table.

## Schedule of Actions Verified as Completed – April to September 2020

| PROJECT WORKSTREAM: Safe and Effective Care | | | | |
|---|---|---|---|---|
| **Action Ref:** | **Source** | **Recommendation** | **Date Verified as Completed** | **Follow-Up Required?** |
| 7.2 | RCOG | Identify nominated individuals to ensure that all **maternity guidelines**:-<br><br>• are up to date and regularly reviewed;<br>• are readily available to staff;<br>• have an MDT approach;<br>• are adhered to in practice. | NEW<br><br>03.08.2020 | Verification based on assessment of documentary evidence and probing conversations with clinicians and managers. May require post-COVID-19 follow up to verify embedded in practice. |
| 7.21 | RCOG | Improve **incident reporting** by:-<br><br>• delivering training on the use of the Datix system for all staff;<br>• encouraging the use of the Datix system to record clinical incidents;<br>• monitoring the usage of the incident reporting system. | RE-VERIFIED<br><br>03.08.2020 | Verification based on assessment of documentary evidence and probing conversations with clinicians and managers. May require post-COVID-19 follow up to verify embedded in practice. |
| 7.23 | RCOG | Improve **learning from incidents** by:-<br><br>• sharing the outcomes from SI's on a regular basis.<br>• sharing in an appropriate, regular and accessible format. | RE-VERIFIED<br><br>03.08.2020 | Verification based on assessment of documentary evidence and probing conversations with clinicians and managers. May require post-COVID-19 follow up to verify embedded in practice. |
| 7.25 | RCOG | Appoint a consultant midwife lead for **clinical audit and QI** to ensure:-<br><br>• clinical audits are MDT;<br>• staff encouraged to complete audit;<br>• sharing of outcomes;<br>• clinically validated system for data. | RE-VERIFIED<br><br>12.08.2020 | 6 month follow up. |

| PROJECT WORKSTREAM: Quality of Leadership and Management | | | | |
|---|---|---|---|---|
| **Action Ref:** | **Source** | **Recommendation** | **Date Verified as Completed** | **Follow-Up Required?** |
| 7.15 | RCOG | Educate all staff on the accountability and importance of **risk management, Datix reporting and review and escalating concerns** in a timely manner. Include this at:-<br>• junior doctor induction;<br>• locum staff induction;<br>• midwifery staff induction;<br>• annual mandatory training. | NEW<br><br>12.08.2020 | Verification based on assessment of documentary evidence and probing conversations with clinicians and managers. May require post-COVID-19 follow up to verify embedded in practice. |
| 7.18 | RCOG | Agree **cohesive methods of consultant working** after the merger with input from anaesthetic and paediatric colleagues. | NEW<br><br>12.08.2020 | Verification based on assessment of documentary evidence and probing conversations with clinicians and managers. May require post-COVID-19 follow up to verify embedded in practice. |
| 7.22 | RCOG | Actively discuss **Serious Incidents**. | NEW<br><br>03.08.2020 | Verification based on assessment of documentary evidence and probing conversations with clinicians and managers. May require post-COVID-19 follow up to verify embedded in practice. |
| 7.29 | RCOG | Closely **monitor bank hours** undertaken by midwives employed by Cwm Taf, to ensure:-<br>• the total number of hours is not excessive;<br>• the Health Board complies with the European Working Time Directive;<br>• these do not compromise safety. | RE-VERIFIED<br><br>03.08.2020 | |

| Action Ref: | Source | Recommendation | Date Verified as Completed | Follow-Up Required? |
|---|---|---|---|---|
| 7.30 | RCOG | Ensure the Medical Director has **effective oversight and management of the consultant body** by:<br>• making sure they are available and responsive to the needs of the service;<br>• urgently reviewing and agreeing job plans to ensure the service needs are met;<br>• clarifying what is to be covered as part of SPA activity (audit, governance, teaching, guidelines, data assurance, train more consultant obstetricians as appraisers);<br>• ensuring the most unwell women are seen initially by a consultant and all women are seen by a consultant within 12-hour NCEPOD recommendation 4 (national standard). | NEW<br><br>12.08.2020 | Verification based on assessment of documentary evidence and probing conversations with clinicians and managers. May require post-COVID-19 follow up to verify embedded in practice. |
| 7.32 | RCOG | Ensure **obstetric consultant cover** is achieved in all clinical areas when required by:<br>• reviewing the clinical timetables to ensure 12 hour cover on labour ward;<br>• undertake a series of visits to units where extended consultant labour ward presence has been implemented;<br>• considering working in teams to ensure a senior member of the team is available in clinics and provide cross cover for each other;<br>• considering the creative use of consultant time in regular hours and out of hours to limit the use of locums. | NEW<br><br>12.08.2020 | Verification based on assessment of documentary evidence and probing conversations with clinicians and managers. May require post-COVID-19 follow up to verify embedded in practice. |
| 7.34 | RCOG | Allocate all trainees currently in post a **clinical and educational supervisor**.<br>• the role of clinical supervisor and educational supervisor should be documented and closely monitored by the Director of Medical Education.<br>• the competency assessments for trainees must be provided in-house under the supervision of the Royal College's tutor. | RE-VERIFIED<br><br>03.08.2020 | Verification based on assessment of documentary evidence and probing conversations with clinicians and managers. May require post-COVID-19 follow up to verify embedded in practice. |

| Action Ref: | Source | Recommendation | Date Verified as Completed | Follow-Up Required? |
|---|---|---|---|---|
| 7.37 | RCOG | Develop a department wide **multi-disciplinary teaching programme**:-<br>• this must be adequately resourced;<br>• time allocated for attendance by all staff groups including specialist clinical midwives and SAS doctors,<br>• attendance must be monitored and reviewed at appraisal. | NEW<br><br>03.08.2020 | Verification based on assessment of documentary evidence and probing conversations with clinicians and managers. May require post-COVID-19 follow up to verify embedded in practice. |
| 7.57 | RCOG | Continue with efforts to **recruit and retain staff**. | NEW<br><br>03.08.2020 | Verification based on assessment of documentary evidence and probing conversations with clinicians and managers. May require post-COVID-19 follow up to verify embedded in practice. |
| 7.62 | RCOG | Independent Board members must **investigate the lack of action by the Executive Team and Board following receipt of the consultant midwife's report** in September 2018.<br>• Independent Board members must challenge the executive over this report;<br>• Independent Board members must ensure they are fully informed. | NEW<br><br>27.08.2020 | |

| PROJECT WORKSTREAM: Quality of Women's Experience | | | | |
|---|---|---|---|---|
| **Action Ref:** | **Source** | **Recommendation** | **Date Verified as Completed** | **Follow-Up Required?** |
| 7.47 | RCOG | Develop and **strengthen the role and capacity of the MSLC** to act as a hub for service user views and involvement of women and families to improve maternity care, and:-<br>• appoint a Lay Chair as a matter of priority;<br>• increase lay membership numbers with appropriate support and resources;<br>• support lay members to engage with women using services in the FMU at RGH and at PCH to assess satisfaction and to identify issues relating to choices;<br>• enhance the MSLC monitoring role in order to assess whether patterns of concerns are found and to ask for regular feedback on action taken. | 03.08.2020 | |
| 7.49 | RCOG | Develop the **range and scope of engagement** with women and families:-<br>• review the effectiveness of patient experience methodology and its impact on service change and improvement as a result of feedback;<br>• as a priority, review and address the monitoring of the outcomes of patient experience as a key part of the governance structure;<br>• feedback the outcomes of all engagement to women and families;<br>• explore methods to hear directly from women and families about their experience including patient stories, diaries, 'mystery shopper' or observation techniques. | 12.08.2020 | |
| 7.52 | RCOG | **Learn from the experience of women and families** affected by events:-<br>• respond and work with families in the way they require7.52 continued,<br>• feed the learning into the design of a comprehensive training and support programme that will give women and families confidence in the skills, expertise, communication, and safety and quality of maternity care. | 03.08.2020 | |

## Schedule of Actions Removed from the Plan – April to September 2020

| Action Ref: | Source | Recommendation |
|---|---|---|
| 7.71<br><br>(DU) | Delivery Unit | Simplify the current processes for review of an incident and make 'patient safety' the focus of the review (rather than grading for external reporting). |
| 7.73<br><br>(DU1a) | Delivery Unit | Develop a log of the aggregated action plans for monitoring of implementation. |
| 7.76<br><br>(DU 4) | Delivery Unit | Ensure sustainable change in the Midwifery reporting process that provides assurance that incidents are being reported and investigated in line with the Putting Things Right requirements. |
| 7.77<br><br>(DU 5) | Delivery Unit | Instigate rapid review of patient safety incidents where care or service delivery problems give rise to concern and implement make safe as actions across the HB. Review the HB methodology for carrying out investigation including the monitoring and implementation of actions. |
| 7.78<br><br>(DU 6) | Delivery Unit | Review the corporate process for the reporting and investigation of all incidents and concerns including the governance arrangements that provide board assurance. Clarify the roles and responsibilities for incident management across the organisation that demonstrates the lines of accountability for the risk management of an incident and cross-organisational learning. |
| 7.79 | Health Board | Maternity theatre to be managed by ACT in line with national standards. |

# Progress Update - Outstanding 'Make-Safe' Actions from April 2020 Progress Report

| 'Make-Safe' Action | Progress Update | Current Status |
|---|---|---|
| 6. There was a lack of **awareness and accessibility to guidelines, protocols, triggers and escalations**. | Over the last six months, a programme of work has been undertaken to review, prioritise and update polices, protocols and guidelines across the three CTMUHB sites. This work has now been completed and the relevant action within the MIP (RCOG recommendation 7.2) has been signed off as delivered by the MIB and ratified by the Quality and Safety Committee. The Panel has reviewed documentary evidence and discussed the application of the policy with medical and maternity staff and has verified that the decision to record the recommendation as delivered is reasonable. A multi-disciplinary Policy Group has been established to oversee the updating of guidelines in future and a forward plan has been established for the next three years. 7 policies require further pharmacological input but it is expected that this will be completed by the end of September 2020. The Panel has previously verified that processes to make guidelines more accessible to staff are in place. It should be noted that work to review and update neonatal policies and guidelines is still in progress. | **COMPLETED. NO FURTHER ACTION REQUIRED.** |
| 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. | A further Birthrate plus® Review was undertaken in the summer of 2019 and the assessment report was received by the Health Board in November 2019. The maternity team took some time to review the findings and some additional work was required to interpret the data, based on local circumstances. The Director of Midwifery has since confirmed that existing establishment levels are fully consistent with Birthrate plus® recommendations and no additional resourcing is required in order to achieve compliance. As previously reported, staffing levels have and continue to be subject to rigorous monitoring and escalation processes at both health board and Welsh Government levels. These remain in place (albeit they are now less intense) and are occasionally observed by the Panel. Staffing levels continue to fluctuate through time. However, the service is operating around its establishment level and any variation is what would be considered as 'business as usual'. Although the Royal Colleges' recommendation has effectively been discharged for some months now, the Panel has been encouraging the Health Board to develop a longer term workforce plan to ensure that there is an ongoing focus on issues like sickness management, use of overtime and that the deployment of staff is regularly reviewed to ensure that best use is being made of the resources available. The Workforce Plan was presented to MIB in August 2020. It has been reviewed by the Panel's Clinical Leads and is deemed to be appropriate. Longer term actions have been reflected in the MIP and will be monitored going forward via the MIB and the Panel's oversight processes. | **COMPLETED. NO FURTHER ACTION REQUIRED.** |

| | | |
|---|---|---|
| 11. The **culture within the service is still perceived as punitive**. **Staff require support** from senior management at this difficult time. | A significant amount of work has been undertaken by the Health Board over the past eighteen months to bring about the change in organisational culture which was highlighted as necessary by the Royal Colleges' report. This work is wider than maternity and neonatal services and forms part of the organisational development programme which has been designed in response to the targeted intervention process. A comprehensive organisational development programme has been designed at Health Board level which includes inputs around leadership development, values and behaviours and mindfulness and this is being systematically rolled out across the organisation. The progress which had been made up to April 2020 in rolling out the programme to maternity and neonatal services was reported in the Panel's previous report. Since that time, the rollout of the programme has been necessarily suspended due to COVID-19 although the Health Board is currently considering how and when it should be reinstated. Culture change takes time and it is still too early to say that this action could be signed off as completed. However, the Panel has seen clear evidence over the past eighteen months that the culture of the organisation is changing for the better and the evidence to support this view is well document in previous reports. The positive change in culture is also reflected in feedback from patients via the PALS surveys, from independent external reviews (e.g. those conducted by the CHC) and from the Panel's independent observations of behaviours amongst staff and senior managers. It is important to emphasise that there has been a significant change in the leadership of the service at all levels. In many respects, although there is still much work to be done, the service now provided is fundamentally different to the one reviewed by the Royal Colleges and the Panel sees no evidence to suggest that in the current environment, the general culture of the organisation is a significant safety issue. That is not to say that the work on changing organisation culture is completed. Indeed, it is questionable whether it is ever possible to say that cultural change has been delivered because it's a complex and an ongoing process. However, progress is being monitored through ongoing actions within the MIP and the issue does not, in the Panel's view, need now to be separately reported on as an ongoing safety issue. | **SUBSTANTIAL PROGESS BUT REMAINS WORK IN PROGRESS.**<br><br>**NB.** Future developments will be monitored via the MIP process. |

# High Level Maternity Improvement Plan

| | Jan- Mar 2020 | Apr – June 2020 | July – Sept 2020 | Oct – Dec 2020 | Jan – Mar 2021 | Apr – June 2021 |
|---|---|---|---|---|---|---|
| SAFE AND EFFECTIVE CARE PROJECT | | | | | | |
| Putting things Right | Improve serious incident and complaint processes to ensure reporting, lear7.20, ongoing and sharing, Reduce complaint backlog and improve women's and families' experience of the complaint process (7.19)<br>Review, triage and learn from Phase 1 Clinical Reviews – commencing January 2020 – targeted completion date April 2021<br>Ensure response to concern and complaints – 7.51 | | | | | Ongoing Monitoring |
| Quality improvement | | Quality Improvement Projects: 1. C-Section Rates 2. Induction of Labour | | | | |
| Quality Control | Urgently review systems in place for data collection (7.1) | | | | | |
| Quality Planning | Development of Business Case for Dignified Care of Women Experiencing Miscarriage (7.7) | | | | | |

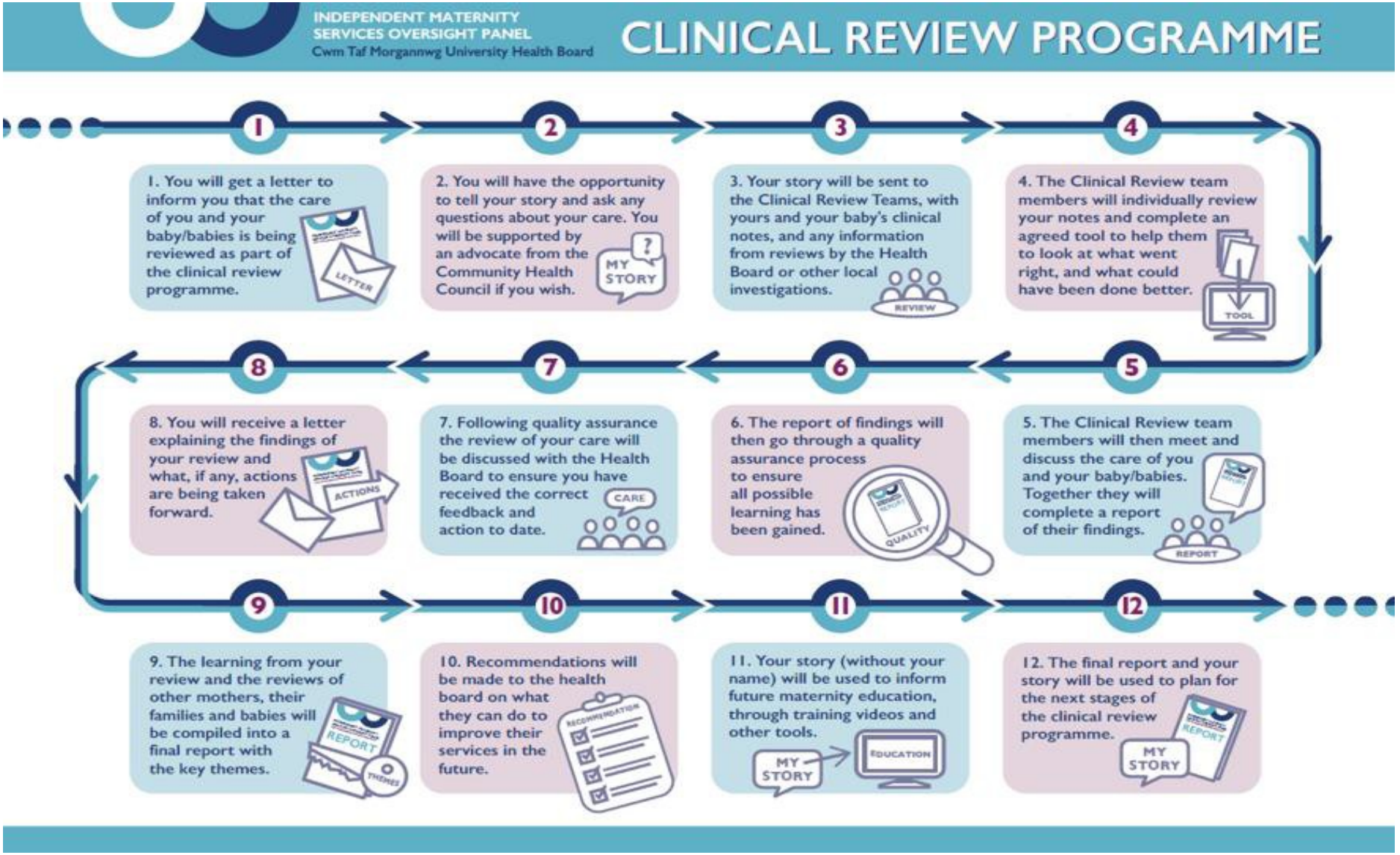
Identifier key: Key Activity | Completion of Recommendation | Sustaining Improvement | Slippage

| | Jan- Mar 2020 | Apr – June 2020 | July – Sept 2020 | Oct – Dec 2020 | Jan – Mar 2021 | Apr – June 2021 |
|---|---|---|---|---|---|---|
| QUALITY OF LEADERSHIP AND MANAGEMENT PROJECT | | | | | | |
| Staff Health and Wellbeing | Development of Staff Wellbeing Plan to include staff survey and programme to reduce sickness rates. | | | Sickness rates within range | Ongoing Monitoring | |
| Workforce Planning | Develop longer term recruitment and retention plans (7.57) Pending | | | | | |
| | Ensure obstetric cover is adequate in all clinical areas (7.32) - pending review | | | | | |
| | Review working practice for consultant cover for Gynae services after the merger (7.39) Sept 2020 | | | | | |
| Skilled Workforce | Undertake and Use training needs analysis for training planning and improve mandatory training and PDR compliance (7.35) | | | | | |
| | Improve and support clinical training compliance (7.17, 7.34, 7.35, 7.37, 7.44, and 7.45) | | | | | |
| | Ensure external facilitation to allow a review of working practice (7.8) | | | | | |
| | Educate staff on the accountability and importance of risk management, datix reporting, escalating concerns (7.15, 7.22) June 2020 – Pending | | | | | |
| Values and Behaviour | Implement Organisational Development Programme and Evaluate Outcomes (7.17, 7.42, 7.56) | | | | | |
| Leadership and Oversight | Appoint new leadership team (7.69) | | | | | |
| | Implement leadership and board development training and develop succession planning model | | | | | |

| | Jan - Mar 2020 | Apr – June 2020 | July – Sept 2020 | Oct – Dec 2020 | Jan – Mar 2021 | Apr – June 2021 |
|---|---|---|---|---|---|---|
| QUALITY OF WOMEN'S AND FAMILIES' EXPERIENCE PROJECT | | | | | | |
| My Maternity My Way | Recruitment drive to recruit additional lay members (7.47) – verified - ongoing monitoring | | | | | |
| Co-Production | **Ongoing** - Work collaboratively with CHC Colleagues, Women & Families - ongoing engagement through various project board and public engagement events and utilise feedback to inform Quality Improvement Projects | | | | | |
| | | Task and Finish Group to improve experience of women and partners (7.49) Pending | | | | |
| Engagement | | Development of co-produced community engagement plan for 2020– 2023 (7.53, 7.54) | | | | |
| Listening Into Action | | | Programme to introduce validated Maternity Patient Reported Experience Measure (PREM) into service (7.52) | | | |
| Maternity Vision | Develop Maternity Vision in partnership with women, families and stakeholders (7.67) | | | | | |

**Identifier key:** Key Activity | Completion of Recommendation | Sustaining Improvement | Slippage

# Clinical Review Pathway



## Self-Referral Pathway

# Self-Referrals

## How we're managing Self-Referrals

**Working in partnership with women and families to answer questions, with a focus on learning and improvement.**

1. If you have questions or concerns about your maternity care and that care was provided on or before 31 October 2018, you can ask for it to be considered under the Self-Referral Process. If you received care after that date, your concerns will be reviewed in accordance with the 'Putting Things Right' procedures managed by the Health Board.
2. If the Self-Referral Process applies to your care, we will look first to see if the criteria set by the Independent Maternity Services Oversight Panel for an independent clinical review are met. If so, we will refer your care to the Panel and they will contact you to directly to explain what will happen next.
3. If the criteria are not met, a Senior Midwife will contact you to talk through your questions or concerns, either by phone or in person. This may include going through previous records and reviews together to see if your questions or concerns can be answered.
4. You might decide at that stage that the questions and concerns which you had have been addressed to your satisfaction. If not, and you wish the matter to be reviewed further, the Lead Midwife will make a recommendation to the Independent Maternity Services Oversight Panel about how best that review might best be conducted.
5. The review could be conducted by the Health Board or it might be appropriate to arrange an independent review All reviews will be conducted in accordance with the 'Putting Things Right' principles The Lead Midwife will explain this process to you and will take your views into consideration when making a recommendation to the Panel.
6. The Independent Panel will consider the Lead Midwife's recommendation, together with the views which you have expressed and decide what is the most appropriate way for the review to be conducted. Their decision will be explained to you together with the reasons for it.
7. When the review has been completed, whether that be by the Health Board or independently, the findings and conclusions will be referred back to the Independent Panel for further consideration. The findings will also be shared with you and you will have the opportunity to ask any further questions.
8. Working with the Panel, we will ensure that any learning which emerges from the review of your care is carefully considered and results in improvements in the way we provide care in the future.

**1**

**PUTTING THINGS RIGHT (PTR)**

The process for managing complaints and concerns in the last 12 months or so.

**2**

**INDEPENDENT CLINICAL REVIEW**

The review of cases in the inclusion criteria for the first phase 2016-2018.

**3**

**SELF-REFERRAL**

To answer questions, concerns and/or to support reviews not managed under 1 or 2.

**Self-Referral Team**

New Lead Midwife in post. In the process of appointing more staff to respond.

**Emotional Support**

The Health Board has commissioned independent counselling services to support women and families.

**How to contact**

CTUHB_Concerns@wales.nhs.uk

or

**01443 744915**

# Next Steps Actions Arising from Spring 2020 Progress Report

| Action | Summary of Progress as at 31 August 2020 | Status |
|---|---|---|
| **Action 1: Thematic Analysis** - The Panel awaits the publication of the thematic analysis of the outcome of the three engagement events held during 2019/20 together with the detailed action plans which emerge from it. | The Health Board has now published its Maternity Services Engagement Plan for 2020/23 which includes a summary of the thematic analysis of the feedback from the 2019/20 engagement events and details of the work programme to emerge from it. The plan was presented to the Panel in August 2020 and will be subject of ongoing monitoring through the MIP and IPAAF processes. Further details are set out in Section 6.2 of this report. A project group has been established to progress the development of PREMS and a business case has been developed. This has recently been approved at corporate level and the funding has been allocated. The timescales for roll out are currently being developed. The Panel believes that this is an important development and will monitor delivery over the forthcoming period (see Next Steps Action 6). | **COMPLETED** |
| **Action 2: Engagement Plan for 2020/21** - The Panel looks forward to the publication of the Maternity Services Engagement Plan for 2020/21 and in particular, to the launch of the feedback monitoring tool which is currently being developed (PREMS). | | **ONGOING** **(See Next Steps Action 6 in September Progress Report)** |
| **Action 3: Complaints and Concerns** - Once approved, the Panel will expect the Complaints and Concerns Improvement Plan to be a regular feature of the Health Board's performance reporting and will expect to see relevant performance metrics included within the next phase of development of the IPAAF. | Progress against the CCIP is now regularly reported on a monthly basis to the Panel and the Health Board's Quality and Safety Committee via the MIB. A reporting dashboard is currently being developed which will inform future assessments against the IPAAF. Early reports suggested improved compliance with PTR timescales and reducing numbers. However, the Panel is concerned that the recurring themes are similar to issues raised by RCOG. This is discussed further in Section 6.3 and will be subject to further monitoring (see Next Steps Action 8). | **ONGOING** **(See Next Steps Action 8 in September Progress Report)** |
| **Action 4: IPAAF** - Further development work is required to consolidate the progress which has been made in developing metrics for the IPAAF, particularly in terms of (i) identifying performance thresholds or targets where appropriate, (ii) supplementing areas where the metrics are limited (especially Quality of Women's and Families' Experience) and (iii) ensuring continued alignment with the emerging all-Wales performance framework. | The IPAAF has been further developed during the current reporting period and a summary is included in Section 4.2 of this report. However, not all of the issues identified have been addressed. Further work is now needed (i) to align the framework more closely to the Health Board's corporate performance framework; (ii) to make better use of quantitative data and benchmarking to inform the assessment process; and (iii) to reflect the transition of the MIP to a continuous improvement process. The Panel has proposed another multi-disciplinary workshop be held in the next period in order to develop a plan for the next phase of its development (See Next Steps Action 4). | **ONGOING** **(See Next Steps Action 4 in September Progress Report)** |

| | | |
|---|---|---|
| **Action 5: Maturity Matrix** - Further development work is required to identify outcome based measures which will enable an objective assessment to be made about what, in each of the performance domains, constitutes achievement of the 'Results', 'Maturity' and 'Exemplar' elements of the Maturity Matrix. | With the agreement of the Panel, the Health Board has deferred this work until the next reporting period in order to enable it to be aligned with developments which are currently taking place at corporate level. Based on the work which has been done in maternity services, the Health Board has adopted the use of maturity matrices within its corporate performance and quality framework. It is important that the maternity services' IPAAF is aligned with work which is currently in progress (See Next Steps Action 4). | **ONGOING (See Next Steps Action 4 in September Progress Report)** |
| **Action 6: Maternity Improvement Team** - The Panel looks forward to receiving the SRO's proposals for replacing the Maternity Improvement Director when she moves on to her new role. | A revised Maternity Improvement Team structure was approved by the Health Board in June 2020 following consultation with the Panel and other stakeholders. The revised arrangements are now largely in place. Further details are provided in Section 8.2 of this report. | **COMPLETED** |
| **Action 7: Neonatal Services** - During the next reporting period, the Panel will pay increased attention to the neonatal service and as a first step, will invite the Consultant Neonatologist to attend a Panel meeting to provide an overview of the service. | Significant progress has been made over the current reporting period in integrating neonatal service improvement into the overall Maternity Improvement Programme. Whilst there is a significant amount of work still to be done, there is now a clear and shared understanding of the issue and a delivery framework has been put in place. Further details are provided in Section 5 of this report. | **COMPLETED** |
| **Action 8: Staffing Levels** - (see Appendix B for a detailed description of the action required). | This action has now been discharged. See Appendix B for further information**.** | **COMPLETED** |
| **Action 9: Guidelines** – (see Appendix B for a detailed description of the action required). | This action has now been discharged. See Appendix B for further information**.** | **COMPLETED** |
| **Action 10: Maternity Improvement Plan (Delivery)** - Recognising current constraints, the Panel expects to see further delivery against the remaining recommendations within the MIP during the next reporting period and a continued focus on embedding those recommendations which have already been delivered. | A further 12 of the 79 actions contained within the Maternity Improvement Plan (MIP) have been 'signed off' as delivered during the current reporting period. This brings the total now completed to 53. In addition, 5 other recommendations which were signed off in previous periods have been re-validated and 6 others have been removed in order to reduce duplication and unnecessary overlap within the MIP. There are 20 actions remaining to be delivered, all of which are work in progress in various stages of completion. A more detailed explanation of the progress which has been made against the MIP is set out in Section 3 of the report. | **COMPLETED** |

| | | |
|---|---|---|
| **Action 11: Maternity Improvement Plan (Development)** - The MIP would benefit from further development to create a more dynamic, more responsive plan which is regularly refreshed to ensure that it delivers continuous improvement rather than address a list of recommendations. | The MIP has undergone significant development work over the last six months which resulted in a revised plan which was signed off by the MIB on 18 August. The plan includes clearer milestones targets and deliverables and is now a continuous improvement plan which contains longer term actions as well as what remains to be delivered from the RCOG recommendations. A more detailed explanation is included in Section 3.5 of this report. | **COMPLETED** |
| **Action 12: Maternity Improvement Plan (Rationalisation)** - The remaining MIP actions should be reviewed and where appropriate rationalised, consolidated or grouped to avoid duplication and to identify those recommendations where changes in circumstance mean they are no longer relevant. | The MIP has undergone significant development work over the last six months which resulted in a revised plan which was signed off by the MIB on 18 August. Whilst the RCOG recommendations remain visible and identifiable within the plan, they have been rationalised and consolidated into a longer term continuous improvement plan. A more detailed explanation is included in Section 3.5 of this report. | **COMPLETED** |
| **Action 13: HIW Unannounced Inspection** - As part of the regular meeting cycle, the Health Board has been asked to provide the Panel with an exception report in respect of any actions arising from the HIW unannounced inspection of Prince Charles Hospital which remain outstanding after the end of March 2020. | A highlight report in relation to the delivery of the action plans which emerged from the unannounced HIW inspections conducted at the three CTMUHB maternity units was presented to the MIB on 18 August 2020. The report indicated that all of the actions had now been discharged and that follow-up audit work had subsequently been conducted to ensure that the actions remained embedded in practice. As such, there were no outstanding actions in relation to the Prince Charles site and it was not necessary for a highlight report to be presented to the Panel. | **COMPLETED** |
| **Action 14: Handovers and Assurance Audits** - The Panel will include a review of the handovers and assurance audits in its programme of reassurance visits for the next reporting period. | Due to the restrictions on social contact and travel imposed by COVID-19, the Panel has been unable to visit the hospitals or to engage directly with staff. There has been a further review of documentary evidence but it has not been possible to observe a handover or an assurance audit meeting. As such, this action has been deferred and will be picked up again, hopefully in the next reporting period. | **DEFERRED DUE TO COVID-19 RESTRICTIONS** |

# 11 GLOSSARY OF TERMS

| | |
|---|---|
| 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 |
| 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 |
| MS | Member of the Senedd |
| 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.*