INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL

Cwm Taf Morgannwg University Health Board

Progress Report
September 2021

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FOREWORD

On 30 April 2019, following the publication of a report setting out the findings of a review conducted jointly by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives (the Royal Colleges), the then Minister for Health and Social Services (the Minister) announced that he was placing maternity services in the former Cwm Taf University Health Board into 'special measures'.

As part of a wider package of measures designed to support his intervention, the Minister appointed an independent panel (the Panel) to provide the oversight which is necessary to ensure that Cwm Taf Morgannwg University Health Board (the Health Board) addresses the failings identified by the Royal Colleges in a timely, open and transparent manner which places the women and families most affected at the heart of the process.

The Panel is required to report progress to the Minister on a six-monthly basis. However, following representations from the Panel about the impact of COVID-19 on the pace and momentum of the Health Board's improvement programme, the Minister agreed to defer the report which was due to be published in April 2021 for six months.

The Minister also accepted a recommendation from the Panel that there should be an increased focus on the Health Board's neonatal services and appointed two neonatal specialists to provide the additional capacity and expert professional knowledge which was needed to reflect this wider remit.

As a result, this report - the fifth to be published to date - covers the 12-month period to September 2021 and summarises any progress made in improving both maternity and neonatal services as well as providing an update on the other aspects of the Panel's work programme. It does not include detailed background information nor does it repeat, other than is necessary to provide context, the analysis and conclusions contained within previous reports.

Alongside this report, the current Minister for Health and Social Services is also publishing the second in a series of thematic reports arising from the Panel's Clinical Review Programme. This second thematic report, which examines the care of mothers and their babies who sadly, were stillborn, can be accessed here on the Welsh Government website.

The same website also provides access to other information, including previous progress reports and the terms of reference for the Panel's work.

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 and a Welsh Government Commissioner for Isle of Anglesey County Council. He is a police officer by background and a former 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 '*Listening to Women and Families about Maternity Care in Cwm Taf*' report. She has extensive experience in patient and public engagement and supported similar work in Morecambe Bay.

Alan Cameron (Obstetric Lead) has over 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 in a large NHS Trust. She is a designated Midwifery Assessor with the Royal College of Obstetricians and Gynaecologists.

Kelly Harvey (Neonatal Nursing Lead) has over 18 years' experience as a Neonatal Nurse and Advanced Neonatal Nurse Practitioner and is currently Lead Nurse for the North West Neonatal Network. She has recently become a member of the National Neonatal Nurses Association Executive Committee.

Alan Fenton (Neonatologist Lead) has over 26 years' experience as a Consultant Neonatologist and was previously President of the British Association of Perinatal Medicine. He was the Neonatologist in the core team of the 2016 National Maternity Review (Better Births) and has been part of the MBRRACE-UK collaborative since 2018.

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1 THE JOURNEY SO FAR

1.1 PROGRESS TO SEPTEMBER 2020

When the Panel last reported in September 2020, it concluded that the Health Board had done remarkably well against the background of the first wave of COVID-19 to maintain focus and momentum in its Maternity Improvement Programme. In doing so, the Panel considered that the Health Board had made further and quite substantial progress in addressing the failings identified by the Royal Colleges.

A further 12 of the 70 recommendations for improvement made by the Royal Colleges had been addressed, bringing the total then delivered to 50. In addition, two of the three outstanding 'immediate make safe' actions which were identified by the Royal Colleges (workforce planning and clinical guidelines) had been embedded, leaving only one (long term cultural change) to be fully and sustainably addressed.

Whilst recognising the Health Board's achievements, the Panel cautioned that the 12 recommendations which had been signed off during that period would need to be revisited once the restrictions on travel and social contact imposed by the COVID-19 response had been lifted. This was necessary because the Panel was operating remotely and there had been no opportunity to visit the hospitals or to speak face to face with staff to assess the extent to which the improvements made had been embedded in day-to-day clinical practice.

Despite the obvious progress which had been made, the Panel emphasised that a significant amount of work remained to be done to deliver all of the Royal Colleges' recommendations and to ensure that the improvements which had been made to that point were embedded in practice and sustainable in the longer term.

Whilst there was cause for optimism going forward, the Panel also warned that the operational challenges of responding to COVID-19 had taken a toll. Frontline staff and senior leaders were visibly exhausted and some non-essential activities like training, Performance and Development Review (PADR) and consultant job planning had been curtailed or suspended. Similarly, important elements of the improvement programme, like the delivery of the culture change programme, the communications training programme and the roll out of the engagement strategy had been necessarily and unavoidably deferred. This meant that some 'catching up' would be required once restrictions on travel and social contact had been lifted and the operational impact of COVID-19 had subsided.

The Panel also advised that most of the recommendations which then remained to be delivered related to longer term and more complex issues like culture change and leadership development. Based on the experience of similar improvement programmes elsewhere, it was clear that these recommendations would take some time to deliver and even longer to have the desired impact.

Taking all those things into account, the Panel warned that it was unlikely that the same level of progress would be seen in the following period and suggested that some loss of momentum should probably be expected.

1.2 Impact of the Second Wave of COVID-19

What the Panel did not know at that time was that the second wave of COVID-19, which began to impact from October 2020 onwards, would have a deeper and more debilitating impact on the Health Board's improvement programme than the first.

In the event, there were high levels of COVID-19 transmission within the communities served by the Health Board and transmission within the hospital environment which meant that working methods had to be adapted to deal with the increased requirement for infection prevention and control. In addition to the operational challenges this created, there was a significant impact on frontline staffing levels, partly due to sickness and partly due to the numbers of staff forced to self-isolate following contact with others who had been infected.

In addition, several key staff members who were integral to the Maternity and Neonatal Improvement Programme, were necessarily redeployed to support their frontline colleagues.

These issues inevitably impacted on the pace and momentum of the improvement programme and a number of planned activities, like the further development of the Integrated Performance Assessment and Assurance Framework (IPAAF), the publication of a 'road map' setting out the next steps in the Health Board's improvement journey and the development of an enhanced delivery plan with clearer milestones and deliverables, were significantly delayed. There was a delay too in the investigation of post-2018 serious incidents which created a degree of risk which is discussed further in Section 5 of the report.

To the credit of the senior leadership team and the staff involved, the Health Board was able to continue to support the delivery of the Clinical Review Programme, although there was some slippage due to capacity issues associated with the impact of the pandemic within the Health Board and within the independent clinical teams recruited to undertake the reviews. This resulted in a slight delay in the publication of the Panel's first thematic report (the Thematic Maternal Category Report) which was published in January 2021.

At the end of February 2021, the Panel conducted an interim assessment of the progress the Health Board had made in the preceding six months and concluded that whilst there were no obvious signs of regression and some evidence that small steps forward had been taken, there had not been as much tangible progress as there had been in previous reporting periods. At the same time, some of the developments in the improvement programme which were expected to have been delivered by that point had not been realised. This was not unexpected given the context in which the Health Board was working at that time.

The Panel was also conscious that the process of preparing for and responding to the publication of the Panel's regular progress reports placed significant demands on the Health Board's resources and this would have represented an additional burden at a time when it was already operating under significant pressure.

On that basis, in March 2021, the Panel wrote to the then Minister suggesting that the publication of the next progress report be deferred for six months to the end of September 2021. The Minister supported the Panel's proposal and made a statement to the Senedd to that effect on 22 March 2021. A copy of the Minister's statement can be accessed here.

In presenting the case for deferring the progress report, the Panel was able to assure the Minister that despite the challenging circumstances in which the Health Board had been operating, the maternity service had 'kept its head above water'. This would almost certainly not have been possible without the improvements in systems and processes and the changes in leadership style and workforce culture which have been delivered in the two years since the Royal Colleges reported. In particular, there had been no signs of regression in any of the key performance indicators (sickness absence excluded) and safe staffing levels had been maintained.

The Panel was also pleased to report that the maternity service had shown commendable innovation and creativity in responding to the implications of COVID-19, particularly in the way it had used social media and other forms of remote technology to engage with women and families using the service and to involve them in co-producing improvements to the service.

Further information about the progress which has been made in terms of engagement with women and families during the COVID-19 period can be found in Section 3 of the report.

In April 2021, as the direct impact of the second wave of COVID-19 began to reduce, a series of meetings took place between the Panel and senior members of the Health Board in order to 'reset and refocus' the Maternity and Neonatal Improvement Programme. Since that time, a series of measures have been put in place by the Health Board to reinvigorate the programme and to regain the momentum which has been lost during the previous period.

Further information about these programme developments and their impact can be found in Section 2 of the report.

1.3 The Panel's Response

Whilst they are insignificant in comparison to those faced by the Health Board, the Panel has also faced its own challenges as a result of COVID-19, not least the impact which the restrictions on travel and social contact have had on its ability to gather and assess evidence of improvement.

The Panel has continued to maintain oversight of the improvement programme throughout the COVID-19 period and has made good use of remote working methods to achieve that. However, the majority of the assessment work which has been undertaken over the past 18 months has necessarily been conducted virtually.

For that reason, it has been difficult to assess evidence of improvement in a robust and thorough way because there has been little opportunity to meet with staff face to face and until very recently, no opportunity to visit the hospitals to assess whether the improvements which have been delivered on paper have been embedded in day-to-day practice.

There has also been a limited amount of on-site inspection activity undertaken by the Health Board's regulators and other reviewing bodies which has again restricted the opportunity for the Panel to triangulate its assessments against evidence gathered by others as has previously been the case. This has now been addressed to a significant extent by a programme of on-site assurance visits which took place in July 2021 and by the Panel systematically observing the Health Board's meeting cycle (see Section 2 for further information). However, it has made the task of gauging the progress which the Health Board has made more difficult than it was prior to the onset of COVID-19.

Against that background, over the last 12 months, the Panel has increasingly focused on the Health Board's neonatal services as emerging themes from the Clinical Review Programme suggested that further, more focused work was needed to improve aspects of the neonatal service and to integrate it more seamlessly with the maternity service for the benefit of service users.

The Health Board was also unable to gain the reassurance it needed in relation to the quality and safety of its neonatal services and on that basis, in March 2021, with the active support of the Health Board, the Panel made a recommendation to the Minister that there should be an increased focus on neonatal services within the oversight process.

The Minister accepted the recommendation and commissioned a 'deep-dive' exercise to assess the quality and safety of the current neonatal service being delivered by the Health Board. The purpose of the Neonatal Deep Dive as it is now entitled, is to provide assurance that the current neonatal service is safe and fit for purpose and if that assurance cannot be provided, to identify areas where further improvements need to be made.

At the same time, the Minister also appointed two neonatal specialists to provide the Panel with the additional capacity and expert professional knowledge to broaden its oversight role. Further information can be found in the Minister's statement to the Senedd on 22 March 2021 which can be accessed here.

The Neonatal Deep Dive commenced in earnest in May 2021 and the team is due to report its findings towards the end of 2021. However, early concerns around the safety and effectiveness of the service have been identified which have been escalated to the Health Board. The key issues identified are safe prescribing, clinical decision making, documentation standards and the neonatal services' integration with maternity services.

The Health Board has welcomed the feedback from the Panel and some immediate improvement actions have been put in place which are being closely monitored by the Health Board's Executive Team, the Panel and Welsh Government officials.

A Written Statement was issued by the Minister for Health and Social Services on 07 September 2021 which provides further detail about the issues identified and the immediate actions which have been taken to address them. The statement can be accessed here.

A more detailed explanation of the background to and purpose of the Neonatal Deep Dive, plus further information about the escalation of concerns about safety and effectiveness, can be found in Section 4 of the report.

The appointment of additional members has provided the opportunity for the Panel to review and refresh its ways of working. This has included reassessing some of the recommendations which have been verified as delivered with 'fresh eyes' to ensure that there is continued progress and the measures which have been taken remain embedded in operational practice.

In the meantime, the Clinical Review Programme, which is looking back at the maternity and neonatal care provided by the Health Board between 01 January 2016 and 30 September 2018 has continued throughout the last reporting period. Good progress has been made, although the pace has slowed slightly due to the clinical commitments of review team members in the response to COVID-19.

Alongside this report the Panel is publishing its second thematic report which examines the care of mothers and their babies who sadly were stillborn. A copy of the thematic report can be accessed here.

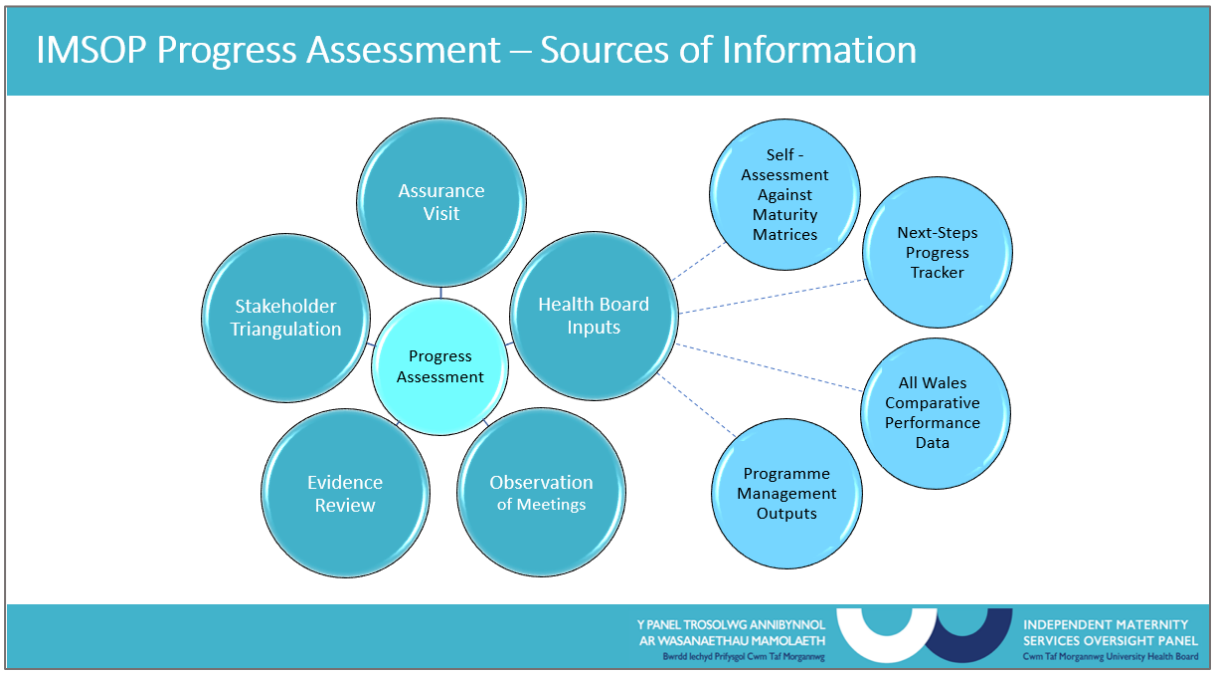
More general information on the Clinical Review Programme, including an update on the Health Board's management of serious incident reviews, can be found in Section 5 of the report.

2 ASSESSMENT OF THE HEALTH BOARD'S PROGRESS

In preparation for the publication of the September 2021 Progress Report, the Panel has drawn together and evaluated information from a range of sources to provide an objective assessment of the progress which the Health Board had made over the past 12 months and more broadly in the two and a half years since the Royal Colleges' report was published.

The diagram in Figure 1 details the main sources of information used as the basis for the Panel's assessment. Some of these individual elements are explored further in the remainder of this section.

Figure 1: *IMSOP Progress Assessment Methodology*



2.1 RECENT DEVELOPMENTS IN THE IMPROVEMENT PROGRAMME

In April 2021, as the direct impact of the second wave of COVID-19 began to subside, a series of meetings were held between the Panel, the Senior Responsible Officers (SROs) and other members of the Health Board in order to 'reset and refocus' the Maternity and Neonatal Improvement Programme going forward.

Since that time, a series of measures has been put in place by the Health Board to reinvigorate the improvement programme in order to regain the momentum lost during the COVID-19 period. These measures include:-

- the appointment of a dedicated Programme Director with considerable experience in managing large scale change programmes and service reform;
- the development of a more robust programme management methodology with a clearer focus on outcomes, deliverables and timelines;

- a revised evidence review process designed to ensure that the evidence which demonstrates the delivery of the remaining Royal Colleges' recommendations is recorded, analysed and challenged, prior to being presented to the Maternity and Neonatal Improvement Board (MNIB) and the Panel for verification;
- enhanced internal monitoring and oversight arrangements delivered through a refreshed MNIB and the Health Board's Quality and Safety Committee;
- the design and delivery of a number of the key 'building blocks' for the next stages of the improvement process (including a 'road map', a revised milestone plan with clearer timescales and deliverables and plans for the development of a 5-year vision for the future of maternity and neonatal services);
- the consolidation of the remaining Royal Colleges' recommendations into a series of high level 'work packages' which form the basis of the milestone plan and the 'road map' leading to the development of the 5-year vision;
- emerging plans to reinstate the culture change, communications and leadership programmes which were deferred as a result of COVID-19;
- closer integration with the Health Board's corporate development programme and better alignment with the assessment framework which has been developed to support the Targeted Intervention Programme.

There have also been encouraging developments in other areas outside the programme management arrangements. For example:-

- appointments have been made to a number of key medical leadership positions which have remained unfilled for some time;
- a realistic plan has been developed, with the support of the NHS (Wales) Delivery Unit, to finalise the outstanding post-2018 serious incident investigation backlog.

Not all of these developments are yet in place; some remain work in progress and others are in the planning stages. However, a substantial amount of progress has been made in a relatively short period of time and in combination, these developments have brought new momentum and a different feel to the improvement programme than existed 12 or even six months previously.

As a result, the Panel believes that having lost focus and momentum over the preceding 12 months, the Health Board's Maternity Improvement Programme is now 'back on the right track'.

It is important to remember that COVID-19 is still very much a live issue. Indeed, as the Panel was completing the drafting of this report, the Health Board was having to re-establish its enhanced command and control arrangements in response to increasing levels of transmission within the community.

Time will tell whether the increased momentum which has emerged over the past six months can be maintained and built upon. However, for the time being, the Panel believes that there is cause for measured optimism.

2.2 Delivery Against The Royal Colleges' Recommendations

One of the key determinants of the Health Board's progress is the extent to which it has and continues to deliver against the Royal Colleges' recommendations.

When the Panel last reported in September 2020, a total of 50 of the 70 recommendations which related directly to the maternity service had been delivered whilst 20 remained work in progress. Many of those outstanding recommendations related to longer term issues like culture change and leadership development which will take time to implement and even more time to deliver the desired outcomes in terms of changes in attitudes and behaviours.

The Panel noted at the time that as a result of restrictions imposed by COVID-19, the process for validating the delivery of the previous tranche of actions had not been as robust as it was in previous reporting periods. Consequently, it has been necessary during this reporting period for the Panel to revisit a significant number of the actions which have previously been verified to ensure that they have been, and continue to be, embedded in operational practice. Further information about the process for re-visiting these recommendations is set out in Section 2.4.

One of the more significant pieces of work which has been undertaken by the Health Board over the last six months has been the revision of their evidence review process to provide a more robust and efficient mechanism for signing-off the remaining Royal Colleges' recommendations as delivered.

The principle of the revised evidence review process is that the Health Board is now the primary assurer of evidence; it places the onus for collating, reviewing and assessing the evidence available upon the MNIB. This approach promotes self-reflection and critical analysis and is welcomed by the Panel.

The role of the Panel within the process is then to review the MNIB decision and to assess the evidence and information on which the decision was based. Having done so, the Panel either verifies the decision reached by MNIB and confirms the recommendation has been delivered, or where it is not able to do so, provides a summary of the additional evidence and information which it believes is necessary to enable the decision to be verified.

Supported by the new evidence review process, the Panel has agreed that there is sufficient evidence to justify another five of the Royal Colleges' recommendations (recommendations 7.39, 7.42, 7.53, 7.54 and 7.69) being signed off as fully delivered within maternity services. That brings the total number of recommendations delivered to 55. It means that almost four-fifths (79%) of the 70 recommendations have now been delivered.

Details of the five additional recommendations which have been signed off as delivered are set out in *Appendix A*.

Although the absolute number of recommendations signed off within the last 12 months is relatively small when compared to the numbers verified in previous periods, for reasons which were explained in Section 1.1, that is not unexpected.

It is also important to emphasise that some of the recommendations which have been delivered in this period are quite significant in terms of the overall improvement journey. For example:-

- the delivery of recommendation **7.54** reflects the fundamental shift which the Health Board has made over the last two years in its overall approach to **engaging with the women and families** who use its maternity services and involving them in the co-production of services (see Section 3 for further details);
- the delivery of recommendation **7.53** reflects the significant investment which the Health Board has made over the past 18 months in enhancing its **corporate communications and engagement capabilities**.

The evidence review process is a continuous one. Detailed feedback has already been provided to the Health Board on a further three recommendations which the Panel believes will be fully delivered and ready for verification within the next reporting period.

2.3 New Ways of Assessing Improvement

As the number of recommendations which remains to be delivered reduces, the Panel has been seeking new ways to assess whether the recommendations which have been delivered to date are embedded in practice and whether they have resulted in the improved outcomes called for by the Royal Colleges.

Since the onset of COVID-19, an increasing number of the Health Board's meetings have taken place remotely using video conferencing facilities. This has enabled the Panel to attend a range of operational meetings to observe the day-to-day functioning of the maternity and neonatal service. It has also provided increased opportunities for the Panel to assess the way in which the MNIB, the Quality and Safety Committee and the Board are providing scrutiny and challenge to the delivery of the improvement programme.

A systematic approach has been adopted and this has effectively provided the opportunity for the Panel to observe the management and oversight of the maternity and neonatal services and the improvement programme 'from Board to Floor'.

Although some opportunities for improvement have been identified and fed back, in broad terms, the Panel has been reasonably assured that as far as the maternity service is concerned, the systems and processes which have been put in place over the past two and a half years are increasingly contributing to the delivery of a safe and effective service where the needs of women, their babies and their families are at the forefront of the Health Board's thinking.

By way of example, in recent months, the Panel has observed the following meetings and provided feedback to the Health Board in the following terms:-

- **Maternity and Neonatal Improvement Board (June 2021)** - *'The MNIB was well organised, well chaired and effectively managed with multidisciplinary representation at executive and senior level. There was a positive atmosphere*

and a sense of shared endeavour. The agenda was well structured and clearly focused on the key issues requiring discussion. It was encouraging to see a strong alignment between the agenda and issues which have been raised by the Panel in recent months.'

- **Health Board Meeting (July 2021)** - *'In comparison to [a previous Board meeting which was observed], there was a marked step up in terms of the level and quality of scrutiny and challenge provided by Independent Members (IM's) in relation to the maternity and neonatal improvement item. Five different IM's asked questions or provided comments which were relevant and demonstrated a good level of insight into the issues and risks which the Health Board is managing in this area. There was a clear theme within IM interventions around the interests of women and families using the services and officers responded openly and constructively to the questions and comments raised.'*

- **WESEE (Workforce, Effectiveness, Safety and Experience and Engagement) Meeting (June 2021)** - '*The discussions which took place indicated a proactive and robust approach to tackling sickness absence and achieving compliance [for example in respect of mandatory training] but this appeared to be balanced with a genuine concern for staff and their well-being. Any gaps in data were recognised and discussed and actions were appropriately identified to address them.'*

- **Maternity Guidelines Group (June 2021)** - '*The maternity guidelines group meeting was well attended with multidisciplinary involvement at a senior level from both Prince Charles Hospital and Princess of Wales Hospital. There is a clear long-term plan in place to ensure that guidelines remain current and are regularly reviewed and refreshed at appropriate periods. There was a discussion about how the guidelines which had been signed off during the meeting were to be disseminated and clear actions and accountability for doing this were agreed.'*

The purpose in highlighting this aspect of the Panel's assurance work is to demonstrate that whilst there has been less delivered in terms of progress against the Royal Colleges' recommendations in the last 12 months when compared to previous periods, observing the Health Board's meeting cycle has enabled the Panel to gain assurance that the systems and process which were put in place in the early stages of the improvement programme are now becoming embedded in practice and delivering the improvements which the Royal Colleges called for.

2.4 PANEL ASSURANCE VISIT – 19/20/21 JULY 2021

In July 2021, the Panel spent three consecutive days in the Health Board, reviewing progress and looking for evidence that the improvements which have been made since the Royal Colleges' review remained embedded in practice and were making a difference to the quality and safety of the care provided to women and their babies.

Some Panel members were physically present for part of that time, whilst others who were unable to travel due to local COVID-19 transmission rates joined remotely. The Neonatal Deep Dive team also participated virtually as part of their evidence gathering and assessment work.

The Panel visited the maternity and neonatal units at both Prince Charles and the Princess of Wales Hospitals,[1] meeting with frontline staff, supervisors and managers. They also met with members of the Maternity and Neonatal Improvement Team, including workstream leads, improvement directors, SRO's and Board members with responsibility for overseeing the programme.

The Panel engaged in a structured programme of activities including staff focus groups, one to one interviews and ward visits. They also observed operational activities, including handovers and team briefings. The opportunity was also taken to physically check that things which the Panel had previously been assured were in place, for example, that clinical guidelines and regular equipment checks were being utilised in practice. Although it was not possible to meet with service users, the Panel did take the opportunity to gauge the extent to which the Health Board's engagement work was making a difference to the experiences of women and families.

This was the first opportunity to visit the hospitals and to meet face to face with staff since the onset of the COVID-19 response in March 2020. As such, it provided a valuable opportunity to re-establish the Panel's visibility and to gauge the extent to which staff were engaged in and committed to the improvement process.

The Panel's more detailed assurance work, focused specifically on 21 individual recommendations which had been selected for one of three reasons, namely:-

(i) they had been signed off during the preceding 12 months and there had been no previous opportunity to triangulate evidence or gain assurance that the improvements which had been made were embedded in practice;
(ii) they had previously been identified as needing ongoing monitoring;
(iii) questions had been raised about impact, either as a result of the Clinical Review Programme, the serious incident review process or as a result of the impact of COVID-19 and it seemed sensible to undertake further validation.

The evidence and information which was gathered during the three days was collated and the Panel held a workshop on 09 August 2021 to draw out some conclusions from the visit. Some minor operational issues were identified and fed back to the Health Board for follow-up action. However, there were no major surprises or concerns and on balance, the Panel felt that the maternity service had made incremental progress during the preceding 12 months.

As expected, given the impact of COVID-19, the pace of progress has been slower than the Panel would have hoped for. In some areas, there has been some regression, although where that is the case, the reasons for that are clear and there are plans and trajectories in place to recover the ground which has been lost. In particular, the Panel were reassured that:-

- guidelines, protocols and procedures have been reviewed, updated in accordance with national standards and are now readily available to all staff;

[1] *The visit to Princess of Wales was conducted virtually in order to avoid the risk of COVID-19 transmission between the two sites.*

- consultant presence has been increased, on-call arrangements strengthened and trigger lists developed to ensure appropriate responses to escalating risk;
- a multidisciplinary clinical audit programme has been implemented, supported by a nationally recognised compliance monitoring system which can be accessed in real-time from 'Ward to Board';
- a revised clinical governance framework has been established and is being applied in practice enabling safety and quality issues to be better managed;
- arrangements for sharing learning from incidents have been strengthened with thematic learning events being hosted by the maternity and neonatal teams;
- nationally designed mandatory training programmes have been delivered for both nursing and medical staff and although these have been impacted by COVID-19, there are realistic trajectories in place to bring them back on track;
- hospital and community-based PROMPT (Practical Obstetric Multi-Professional Training) has been delivered and the national target of 95% compliance has already been exceed;
- an extensive programme of events and other mechanisms have been developed to improve engagement with women and to learn from their experiences;
- the My Maternity My Way forum has emerged as an effective mechanism for listening to women's voices and engaging them in the design and delivery of services going forward.

Based on the three days spent visiting the Health Board, the Panel concluded that whilst there is still work to do, the improvements which have been made in the maternity service over the last two and a half years have largely been consolidated and remain embedded in operational practice.

The Panel did not reach any firm conclusions about progress against the neonatal elements of the improvement plan because the Neonatal Deep Dive work is still in progress. However, some concerns were identified, which are discussed further in Section 4 of the report and will be reported fully when the work has been concluded.

Although there was an overall sense of progress having been made in the maternity service, the Panel concluded that ten of the Royal Colleges' recommendations require ongoing monitoring and as such, will need to be re-assessed again in six months' time. The reason for that tended to fall into one of three broad categories:-

(i) they require medical leadership and the recent appointees to key medical leadership positions need time to establish themselves in their roles;
(ii) they relate to issues which have been impacted by COVID-19 and some recovery work is needed to get back on track;
(iii) they relate to ongoing work, for example, the work being undertaken with the support of the NHS (Wales) Delivery Unit to strengthen serious incident investigation.

Details of the ten recommendations which require ongoing monitoring are set out in *Appendix B*. The Panel will re-assess progress against these recommendations over the next six months and report further in March 2022.

As well as providing an opportunity to assess maternity services' progress against the Royal Colleges' recommendations, the assurance visit also provided the opportunity for the Panel to draw some wider conclusions about the improvement process which were fed back to the Health Board at the end of the visit. These can be summarised as follows:-

- although staff were clearly tired and operating under significant operational pressure, they were generally positive in their outlook;
- despite those pressures, there was an overriding sense of commitment at all levels and a genuine focus on the needs of service users;
- there was a sense of measured confidence, particularly amongst managers, specialists and those involved directly in the improvement programme;
- whilst there is clearly pride in what has been achieved to date, there is also a sense of realism about how much remains to be done;
- there was an increased feeling of openness and transparency and staff were as willing to talk about the problems they faced as well as their successes;
- there was more of a shared sense of direction than had previously been experienced, with key staff able to articulate future plans more clearly.

Against that generally favourable background, the Panel did identify some areas where the Health Board needs to focus attention going forwards, namely:-

- although the transition to the Integrated Locality Group (ILG) operating model is a positive development because it has brought the maternity and neonatal service together into the same directorate, there appear to be some early tensions which need to be worked through, particularly in relation to risk management, closure of serious incident investigations and the management of complaints and concerns;
- in particular, the Panel was unable to draw firm conclusions about how effectively the new ILG operating model is interfacing with the special measures and the MNIB governance arrangements and this will need to be explored further in the coming weeks;
- recent senior medical appointments provide a real opportunity to increase medical engagement and ownership in the improvement process but this now needs a concerted effort and strong leadership;
- the need to better integrate maternity and neonatal services was further re-enforced through observations and conversations with staff.

These issues have been fed back to the Health Board and will be factored into the development of the work packages which will form the basis of the next steps for the improvement programme.

2.5 STAFF ENGAGEMENT

During the three-day visit, the Panel met with a range of staff at various levels and in different roles, both as individuals and in larger focus groups.

For the most part, the conversations were positive ones. However, there was a noticeable difference in the tone of the conversations with managers, specialists and staff who are involved directly in the improvement programme and those with focus groups involving frontline staff.

Conversations with frontline staff tended to be dominated by concerns about workloads, staffing issues and system pressures. When asked direct questions, the responses from staff provided confirmation that improvements have been made over the past two years in the way that the service is provided.

By way of example, they were able to confirm that escalation procedures had improved, that there was increased consultant presence and that they had access to up-to-date guidelines and protocols which supported their work.

There were also clear indications of an improved team ethos, better relationships with first line supervisors and managers and improved attitudes towards women and families. However, this information was not readily offered and invariably had to be 'teased out' by asking the right questions.

It is not always helpful to draw firm conclusions from informal conversations with a relatively small number of people. However, the Panel was left with a sense that there is some 'disconnect' between the improvement programme and the staff on the ground who are delivering services.

That is not unusual at this stage in a major change programme on this scale. It is also perhaps understandable given the challenges which the staff on the frontline have faced in the last 18 months. However, it re-enforces the importance of engaging frontline staff more closely in the improvement journey and rolling out at pace the culture change, communication and leadership programmes which are currently being developed.

2.6 Stakeholder Engagement

During July 2021, the Panel consulted with key stakeholders with the aim of triangulating its assessment of progress against information held by other bodies. This included conversations with regulatory bodies such as Healthcare Inspectorate Wales, Audit Wales, the Nursing and Midwifery Council and the General Medical Council, plus statutory bodies including the Community Health Council. In addition, conversations took place with organisations who provide developmental support to the Health Board including Health Education and Improvement Wales.

Given the impact of COVID-19, there has been a limited amount of on-site inspection activity in relation to the Heath Board's maternity and neonatal services over the past 18 months. As such, nothing particularly significant emerged from the stakeholder conversations in terms of tangible evidence which would inform the Panel's conclusions. Equally, there was nothing which suggested that the Panel's assessment of the Health Board's progress was not reasonable either.

The Panel did note that the Cwm Taf Morgannwg Community Health Council has recently published the findings of a survey of the experiences of women and families who received care at the Tirion Birthing Centre in the Royal Glamorgan Hospital between March and June 2021. A copy of the report can be accessed here.

The report concludes that the majority of women who responded to the survey did not have any concerns about their care or treatment and a number provided positive feedback about their birthing experience and about the care and support that they received from staff. Other key messages from the report were that:-

- the majority of women were given a choice about where they gave birth although only 60% had help from their midwives in making a birth plan;
- the majority of women said that their birthing partner was able to stay with them throughout their labour although where partners were asked to leave, this had an impact on women's overall birthing experience;
- the majority of women felt that they had received adequate information to help them decide whether to breast feed or not.

As a snapshot of women's experiences in one of the Health Board's maternity settings, those findings are encouraging and tend to support information from other sources, for example social media, the My Maternity My Way forum, as well as compliments received. This suggests that the experience of a significant number of women receiving care and treatment in the Health Board is a positive one.

However, it is important that the Health Board ensures that the PREMs system, which will provide a much richer picture of women's experiences across the Health Board area, is implemented at the earliest opportunity. This issue is discussed further in Section 3.1 of this report.

The feedback on breastfeeding also reflects comments from other engagement about the need for increased information and support for women to make choices. The Health Board has made breastfeeding a key priority and is engaging in co-production with the My Maternity My Way forum and women and families.

2.7 Progress Against Next Steps Actions

When the Panel last reported in September 2020, it identified ten 'next steps actions' which would provide a focus for the Health Board in the next period.

Given that these actions were intended for completion within the following six months, the majority have now long been actioned and completed. As such, the Panel does not intend to dwell significantly on these actions.

However, a summary of the 'next steps actions' and the action taken by the Health Board in response is included at *Appendix E*.

It will be seen that three actions remain work in progress, namely:-

- Action 3 which relates to further development of the Maternity and Neonatal Improvement Plan;
- Action 7 which relates to the management of complaints and concerns, and;
- Action 10 which relates to the investigation of serious incidents.

These issues are explored in more detail in Sections 2, 3 and 5 of the report respectively.

2.8 Current Assessment Against the Maturity Matrix

When the Panel last reported in September 2020, it concluded that whilst the Integrated Performance Assessment and Assurance Framework (IPAAF) had developed over the previous 12 months, it could be strengthened further.[2]

A workshop was held in December 2020 involving the Panel, the Health Board and the Welsh Government and it was agreed that the IPAAF would be enhanced by:-

(i) aligning the framework more closely to the Health Board's corporate performance framework and targeted intervention assessment framework;
(ii) providing more explicit descriptors for the maturity and exemplar phases;
(iii) making better use of quantitative data to inform the assessment process; and
(iv) reflecting the transition to a continuous improvement process.

Unfortunately, this work has not been fully progressed as a result of the operational pressures associated with COVID-19. There have been some enhancements to the framework in that the statements within the maturity matrices have been reviewed and aligned with the corporate performance framework. However, further work is still required to enhance the IPAAF so that it becomes a more effective tool for monitoring and assessing service improvement over time.

This work has been scheduled into the Health Board's work plan for the next period and it is anticipated that when the Panel next reports, the enhanced IPAAF will be available and will be used as the basis for the Panel's assessment. However, in the interim, the existing IPAAF model is sufficient to enable the Panel to make an objective judgement about the Health Board's progress over the past 12 months.

During August 2021, the Health Board conducted its third self-assessment against the IPAAF maturity matrices. The self-assessment report was presented to the Maternity and Neonatal Improvement Board for approval on 01 September.

Based on the self-assessment, the Health Board has concluded that the current level of maturity of the maternity service against the three domains is as follows:-

- **Safe and Effective Care** remains firmly in the **'Results'** phase with some aspects of the service approaching 'Maturity';
- **Quality of Women's Experience** is now firmly in the **'Results'** phase with many aspects of the service approaching 'Maturity';
- **Quality of Leadership and Management** is now firmly in the **'Results'** phase with some aspects of the service approaching 'Maturity'.

[2] *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.*

These assessments are shown pictorially in Figure 2.

Figure 2: *Maturity Assessment – August 2021*

	MATERNITY SERVICE - 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.

The Panel's assessment is based on a number of elements including evidence of delivery against the Royal Colleges' recommendations, evidence gathered from meeting observations, the site visit and triangulation with external sources.

Some examples of key developments which have been delivered in the last twelve months and have contributed to the current assessment include:-

- in line with the Royal College of Midwives Leadership Manifesto, the Health Board has consolidated the senior midwifery leadership structure with the permanent appointment of a Director of Midwifery, Gynaecology and Integrated Sexual Health supported by two locality-based Heads of Midwifery;
- the medical leadership cohort has been strengthened with each Integrated Locality Group Clinical Service Group (CSG) now having an established senior team consisting of a CSG Manager, Head of Midwifery, Head/Deputy Head of Children and Young People (CYP), CSG Director for Obstetrics and Gynaecology and CSG Director for CYP;
- in support of this revised structure, a Leadership Programme for Consultants and Senior Midwives has recently been completed;
- Board level leadership and ownership of the improvement work is now evident and regular challenge and scrutiny appears to be increasingly present throughout committee and Board meetings;

- the maternity service has joined the new all-Wales midwifery student recruitment streamlining process; this is complemented by a competency package for Band 5 midwives which has been further developed and a robust three-week induction programme has been established;
- further development of the My Maternity, My Way forum has resulted in the co-production of information and resources, the communication of information about service improvement to women and families and a programme of work designed to tackle equality and diversity issues.

It is important to point out that some of these developments have been driven by the Health Board's continuous improvement work, rather than being a direct response to a recommendation made by the Royal Colleges. This serves to emphasise the need, highlighted in Section 2.10, for a different approach to monitoring and evaluating progress going forward.

2.9 Health Board Comparative Performance

On 13 May 2021, the Welsh Government released a statistical overview of maternity and births in Wales. The release is published on the Welsh Government website and can be accessed here. The release covers a five-year period from 2016 to 2020.

The information and analysis on which the release is based was sourced, in part, from the Maternity Indicators (MI) dataset which combines a child's birth record with their mother's initial assessment record. This provides a rich source of data which is used to inform the development of the Welsh Government's maternity policy and strategy.

At the present time, all statistics produced on the basis of information sourced from the MI dataset are experimental in nature. There are some issues around the completeness of the data which are explained in more detail within the release. The data enables the Health Board's performance to be compared against the other health boards in Wales across a range of indicators. The data has recently been used as the basis for the Health Board's Annual Maternity and Neonatal Performance Review with the Welsh Government.

This is the first time that the Panel and the Health Board have been able to access this type of benchmarking information and a number of conclusions can be drawn as set out in the remainder of this section of the report.

The Health Board's maternity service is broadly comparable with other health boards in Wales in a number of key areas. This includes, for example:-

- women receiving their initial assessment before 10 weeks of their pregnancy;
- caesarean section births;
- instrumental births (via ventouse or forceps).

The data indicates that the Health Board compares less favourably than other health boards in Wales in relation to the incidence of stillbirth.

Higher rates of stillbirth are often linked to population health issues including obesity, smoking and social deprivation. The Panel's Thematic Stillbirth Category Report, which is published alongside this report, covers those issues in some depth.

It is not surprising therefore, to see that the Health Board also compares less favourably than other health boards in Wales in those areas which relate to population health, for example:-

- % diagnosed as obese at initial assessment;
- % of smokers at initial assessment.

Corporately, the Health Board is increasingly focusing on improving population health and a package of measures have already been put in place to address the areas where the Health Board's performance is less favourable. This includes, for example:-

- reviewing the provision of mental health care and support for pregnant women and engaging with the All Wales Perinatal Mental Health Team to provide additional training for midwifery staff;
- deployment of the 'Bump Start' (Maternal Obesity Support Service) programme on an organisation-wide basis and ensuring that women receive support and continuity from their community midwife for healthy weight management;
- deployment of the 'MAMMS' (Models for Access to Maternal Smoking Cessation Support) programme organisational-wide;
- seeking reaccreditation against the World Health Organisation's Baby Friendly Initiative which supports mothers to make informed decisions about feeding their baby/babies (this has already been achieved in Princess of Wales Hospital for both neonates and maternity).

It is also intended that population health initiatives will feature strongly within future strategy development and the five-year vision for the maternity and neonatal services. The Panel will report further on the early success of these initiatives when it next reports progress in Mach 2022.

2.10 Assessing the Health Board's Progress – Next Steps

At the end of the current reporting period, from a maternity service perspective,[3] the Health Board has now delivered 55 out of the 70 Royal Colleges' recommendations with ten of those requiring further follow-up to ensure that the improvements which have been put in place are embedded in practice and having a positive impact.

That means that only 15 of the original Royal Colleges' recommendations now remain to be delivered and a number of those are reaching the stages where they will be ready for sign off in the next period.

[3] The neonatal specific Royal Colleges' recommendations will be reviewed as part of the deep dive exercise and progress against them will be detailed within the concluding deep dive report.

The majority of the recommendations which have been delivered to date by the maternity service have been broadly transactional in nature; they relate to improvements in the systems and processes which need to be in place to ensure that the service provided is safe and effective, well led, well managed and focused on the needs of service users.

By contrast, those recommendations which now remain to be delivered are largely transformational in nature. They relate to issues like strategy, cultural change and leadership development which will take longer to deliver and longer still to produce the outcomes which are required.

As such, the Panel believes that the improvement journey, certainly in so far as the maternity service is concerned, is moving into a different and more complex phase which has and will increasingly go beyond the Royal Colleges' recommendations. The Panel is therefore working with the Health Board to find more effective ways to report on progress, whilst ensuring it is still aligned to the Royal Colleges' recommendations.

The Health Board has also recognised the shift from the transactional to the transformational and is redeveloping its improvement programme around a series of work packages, a milestone plan which will change and evolve as the improvement journey progresses and a 'road map' which sets out the next steps in the improvement journey.

This will ultimately lead to the development of a new five-year vision and strategy for the maternity and neonatal service towards the end of 2021.

The work packages, the milestone plan and the road map are well advanced and the Panel anticipates that it will be in position to describe these more fully when it next reports in March 2022. There are seven work packages in total, covering strategy, culture, leadership, governance, women's experience, data and training.

This holistic and more dynamic approach is very much welcomed by the Panel. It will allow learning from the Clinical Review Programme, the Neonatal Deep Dive and the Health Board's continuous improvement work to be incorporated into the improvement plan as it emerges.

Given the way in which the improvement programme is evolving, the Panel and the Health Board have agreed in principle that when the Panel next reports, there will be a shift away from using the Royal Colleges' recommendation as the key determinant of progress to an approach based on the work packages, the milestone plan and the Integrated Performance Assurance and Assessment Framework (IPAAF). This in the Panel's view, will provide a more meaningful assessment of the Health Board's progress, given that each of the work packages will include clear output measures and metrics to enable progress to be evaluated and assessed in an objective way.

This does not mean that the remaining Royal Colleges' recommendations are being disregarded or dismissed. Indeed, they will remain central to and clearly visible within the work packages. However, the Royal Colleges' recommendations were based on a snapshot in time. Since then, the service and the context in which it operates has changed significantly and it is now timely to move beyond the delivery of the recommendations to a longer-term, whole system approach.

The Panel will work closely with the Health Board during the next period to develop a revised assessment framework and the outcome of those discussions will be reflected when the Panel next reports in March 2022.

3 ENGAGEMENT WITH WOMEN AND FAMILIES

When the Panel last reported in September 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 and its wider communities.

Over the past two years there has been a fundamental shift in the Health Board's overall approach to engaging with women and families and this has resulted in increased confidence amongst those using the service. There is now an obvious and genuine belief in the value of engagement within the Health Board and the structures are in place to make this shift sustainable in the longer term.

COVID-19 has clearly impacted on the way in which the Health Board has been able to engage with its communities. However, creative use of social media and other forms of remote technology to engage and build co-production with women and families using the maternity service in particular, has allowed the Health Board to make further progress in this area. These new approaches have been successful in reaching out to many more local people than would have been involved previously.

3.1 RECENT DEVELOPMENTS IN ENGAGEMENT AND COMMUNICATION

One of the next step actions arising from the Panel's previous report was the development of an Engagement Cycle process map. This was included within the Health Board's Engagement Plan for 2020-2023 which was finalised and shared with the Maternity and Neonatal Improvement Board in December 2020. The plan encompasses the multiple methodologies that the service currently has in place in order to engage with service users and capture feedback, in addition to other approaches which the service has committed to put in place within the near future.

A comprehensive showcase presentation has been developed by the Consultant Midwife (who is also the Quality of Women and Families' Experience Workstream Lead) detailing the Health Board's engagement journey since the Royal Colleges' recommendations were written. It is very impressive. The presentation highlights how engagement work has been widened and strengthened over this time and demonstrates the way in which COVID-19 created the opportunity for innovation which has been seized upon by the service to good effect.

Another of the next steps actions which was identified by the Panel in its previous report was the implementation of PREMs (Patient Reported Experience Measures). The measure (in the form of a survey) will focus on gathering and assessing women's experiences based on the quality of the care they receive rather than focusing on their health status or the outcomes of their care and treatment. PREMs is hosted by a system called Civica. The surveys have now been built in co-production with the women and families who use the service and work is now being undertaken to enable the data to be captured and analysed. It is anticipated that the system will be live by the end of September 2021, with data being continuously generated to produce a more sophisticated and in depth picture of women's experience.

3.2 Next Steps In the Engagement Journey

Despite the significant progress which has been made within the maternity service, there is still more to be done to fully deliver the Health Board's plans and to ensure that the changes which have been delivered to date are driving improvement and service design in a way which provide real benefits for women, their babies and their families using the service.

In particular, PREMs has only just been launched and as a result of COVID-19 halting the Patient Advice and Liaison Service (PALS) surveys, there has been no objective analysis of women's experiences for the past 18 months. The roll-out of the engagement strategy has also been curtailed due to the pandemic response. It is important, therefore, that the Health Board regains momentum in this area over the next six months so that the solid foundations which have been created can be maintained and built upon further. The actions which would demonstrate that momentum has been maintained include:-

- the engagement strategy being refreshed and rolled out as COVID-19 restrictions permit, so that the wide range of engagement and communication methods which reach into all communities provide a source of regular feedback of women's and families' experience;
- mechanisms for the collection and analysis of the feedback from PREMs being fully in place and key themes and issues being routinely reported and addressed in a systematic way;
- staff at all levels, including medical staff, understanding the value of engagement as a driver for service change and improvement and being consistently involved, as well as committed to the principles of co-production;
- the neonatal service demonstrating that it has learned from what has been done in maternity and is developing an integrated approach to engagement and communications going forward.

The Health Board recognises these important next steps and is building the necessary actions to deliver them into its work packages and the milestone plan which supports them. The Panel will continue to monitor developments to make sure that the actions result in tangible outcomes for women and families using the service.

3.3 Complaints and Concerns

When the Panel reported in September 2020, it acknowledged that the Health Board was responding to complaints and concerns in a more timely manner. However, some emerging themes still reflected issues highlighted in the Royal Colleges' review. Although, in the early part of this reporting period, the maternity service made headway in responding and learning from recurrent themes, more recently, there appears to have been some regression which appears to be linked to the transition to the ILG leadership and management structure. Work is ongoing to develop stronger links back to the service to ensure valuable learning is not lost. However, this is something that the Panel and the Health Board will need to monitor going forward.

4 NEONATAL SERVICE IMPROVEMENT

The Panel and the Health Board have long agreed that the integration of maternity and neonatal services is an important prerequisite for the delivery of a safe and effective end-to-end service which focuses seamlessly on the needs of women, their babies and their families. In the early stages of the improvement process, for reasons which are well documented, there was an immediate focus on the maternity service 'make-safe' aspects of the Royal Colleges' recommendations. This meant that the neonatal service did not initially receive the same degree of scrutiny as the maternity service in the early stages of the delivery of the Health Board's improvement programme.

When the Panel last reported in September 2020, the neonatal service was self-assessed by the Health Board as making 'early progress' against the maturity matrices in the three IPAAF domains.[4] By contrast, the maternity service was assessed as being in the 'results' phase in all three of the domains. That was understandable given the focus which had been applied to that point. However, the Panel and the Health Board agreed that going forward, there was a need for a greater focus on the neonatal aspects of the improvement programme.

The ambition to develop a more integrated service took a significant step forward in May 2021, when neonatal and maternity services were brought together in structural terms as part of the Women and Children's Directorate which was established in the transition to the Integrated Locality Group operating framework.

4.1 INCREASED FOCUS ON NEONATAL SERVICES

As the focus on neonatal services increased, a dedicated Senior Responsible Officer, a Director of Neonatal Improvement and a dedicated Neonatal Improvement Team were appointed. In order to provide a focus for the improvement work, 16 of the 70 Royal Colleges' recommendations were identified as having direct relevance to the neonatal service and formed the basis of a neonatal improvement plan.

By February 2021, some initial improvement work had been undertaken in order to address the 16 recommendations and the Health Board believed that 9 of those were ready to be signed off as delivered. However, the Panel was unable to determine whether the recommendations had been delivered, partly due to the impact of COVID-19 and partly as a result of a lack of specialist knowledge within the Panel to undertake the assessment.

At the same time, concerns were emerging from the early stages of the neonatal component of the Clinical Review Programme which suggested that some of the failings which had been identified by the Royal Colleges in relation to the maternity service, might also be present within the neonatal service. Those concerns were amplified by the emerging learning from the Health Board's own Perinatal Mortality

[4] *The three workstreams for neonatal improvement are: Safe and Effective Care; Quality of Families' Experience; and Quality of Leadership and Management. These reflect the maternity improvement workstreams and are managed in parallel.*

Review Tool (PMRT) reviews of serious incidents relating to neonatal deaths which had occurred since October 2018.

In response to this emerging picture, neither the Health Board nor the Panel was able to provide the level of assurance required that the problems identified from the historical clinical reviews and serious incident investigations were not present in the current day service.

As a result, it was agreed that some further diagnostic work was urgently required to improve the collective understanding of the situation. The Panel was particularly encouraged that much of the impetus to undertake this additional diagnostic work was being provided by the Chair and independent members of the Health Board's Quality and Safety Committee.

In March 2021, with the active support of the Health Board, the Panel made a recommendation to the then Minister that there should be an increased focus on neonatal services within the oversight process.

The Minister accepted this recommendation and authorised the commissioning of a Neonatal Deep Dive exercise to assess the quality and safety of the neonatal services currently being delivered by the Health Board.

At the same time, the Minister also appointed two neonatal specialists to provide the Panel with the additional capacity and expert professional knowledge required to undertake the work and to broaden the Panel's oversight role to explicitly include the neonatal service.

Further information about these developments, which were publicly reported, can be found in the Minister's statement to the Senedd on 22 March 2021. A copy of the statement can be accessed here.

The Neonatal Deep Dive was commissioned jointly by the Panel and the Health Board in April 2021. Its aim was to provide a detailed and timely review of current neonatal services, with a focus on safety, effectiveness, learning and improvement.

The primary aim of the work is to assess whether the current service is safe and fit for purpose and if that assurance cannot be provided, to identify areas where further improvements need to be made. In particular, the Neonatal Deep Dive seeks to determine whether the Health Board's current neonatal services are:-

- safe and effective;
- well led and well managed;
- focused on providing a quality experience for women and families;
- integrated with the maternity service to provide a seamless end-to-end service for women and babies;
- effectively integrated within the wider Wales Maternity and Neonatal Network;
- fit for purpose and sustainable in the longer term.

The terms of reference for the Neonatal Deep Dive were agreed with the Health Board who welcomed the review of their neonatal service and are actively engaged in the process.

It is important to emphasise that whilst this work is focused specifically on the neonatal unit at Prince Charles Hospital, the findings will also be applied to the neonatal unit at the Princess of Wales Hospital in Bridgend to ensure that there is consistency of approach and common standards across the Health Board.

4.2 Purpose, Format and Structure of the Neonatal Deep Dive

The Neonatal Deep Dive is being led by the Panel's Neonatal Leads and supported by three highly experienced clinicians who are wholly independent of the Health Board and the Panel's previous work.

The work began in earnest in May 2021 and is being informed by evidence gathered from a range of sources. There are four main phases to the review which are running concurrently, those being:-

(i) clinical case assessments of care provided to the sickest infants presenting to the neonatal service in the 2020 calendar year (i.e. those babies who either sadly died or required transfer out for ongoing intensive care);
(ii) an extensive family 'Listening Exercise' conducted by way of survey;
(iii) a series of structured one to one and focus group conversations with staff and wider stakeholders; and
(iv) a review of documentary evidence pertaining to all aspects of the neonatal service and relevant areas of the Health Board's wider systems and processes.

As of September 2021, the evidence review phase is now complete and the findings which have emerged from this work have informed the other phases, in particular the conversations with staff and wider stakeholders.

A number of engagement sessions have been held with a diverse group of staff and although the majority of these sessions have had to be held virtually due to COVID-19, there has been excellent engagement so far. Future sessions are scheduled to support the diagnostic work as it develops.

The family 'Listening Exercise' recently concluded with an excellent response (there were over 100 responses to the survey) and a significant number of families offering to share their experiences directly. Although some early themes have been drawn from the rich picture emerging, further quantitative and qualitative analysis is being undertaken to fully understand the needs and wishes of the women and families using the neonatal service and to determine how the service can respond to meet those needs.

The clinical case assessment phase is nearing the half way point. This involves the independent assessment of a representative sample of episodes of care provided between 01 January 2020 and 31 December 2020. The episodes of care which are being assessed were identified using the same inclusion criteria as the neonatal category of the 2016-2018 Look-Back element of the Clinical Review Programme but the reviews are specifically focused on the neonatal care provided.

As such, the assessments are intended to supplement the Health Board's internal investigation process, rather than constitute a full clinical review in their own right.

4.3 Escalation of Emerging Concerns

Throughout the review process, the Neonatal Deep Dive team has maintained regular contact with the Health Board, the Neonatal Improvement Team and staff at all levels within the units. Regular meetings have been held to feedback learning as it emerges and any concerns requiring immediate escalation have been raised through the established channels which support the Clinical Review Programme.

In August 2021, informed by triangulation of all the evidence gathered over the preceding three months, including the views of women and families using the service, the team concluded that there were some aspects of the neonatal service currently provided at Prince Charles Hospital which did not meet the standards of safety and effectiveness which it expected to see in a neonatal unit operating at that level within the UK healthcare system.

The concerns identified included safe prescribing, expertise within clinical decision-making, documentation standards and the neonatal services' integration with maternity services.

Those concerns were subsequently escalated by the Panel to the Health Board in order to enable immediate action to be taken improve the safety and effectiveness of the neonatal care currently being delivered. The Health Board accepted the interim recommendations and responded directly and decisively.

The Panel's concerns regarding the safety of the neonatal service were also escalated to the Welsh Government and on 07 September 2021, the current Minister issued a statement to the Senedd setting out the interim findings of the Neonatal Deep Dive and explaining the immediate actions the Health Board had taken in response. A copy of the Minister's statement can be accessed here.

4.4 Immediate Actions Being Taken By The Health Board

In response to the concerns escalated by the Panel, the Health Board took a series of immediate steps to mitigate the risks which had been identified. These included:-

- improvements to prescribing practices;
- enhanced pharmacy support with daily oversight of prescriptions and further work to develop standard operating procedures, checklists and audits;

- revised arrangements to ensure the timely in-utero transfer out of women needing referral to a tertiary unit for safe delivery with the intention of reducing the number of inappropriate admissions to the Prince Charles Hospital neonatal unit;
- enhanced support and closer working relationship with the tertiary unit in University Hospital of Wales in Cardiff;
- the development of a tertiary centre support programme for neonatal nursing staff in the Prince Charles Hospital unit;
- increased intensity of consultant oversight on the unit and an overall increase in the quantum of consultant time allocated to the unit;
- the recruitment of two additional consultants (this measure was already planned with one taking up post in November);
- improving specific aspects of clinical practice, including urgent review of the approach to therapeutic cooling of babies and for those requiring intubation;
- improvements to the standard of documentation, including the introduction of a revised observation chart.

To enable these steps to be taken and to ensure that the improvements made are embedded in everyday practice, it is essential that the Health Board works collaboratively with neighbouring units and works more closely with the Wales Maternity and Neonatal network.

The Panel will work with the Health Board in the coming weeks and months to monitor and support the delivery of these immediate actions to ensure that the necessary focus and momentum is sustained and improvements in the safety of the current neonatal service are realised. The Panel will report in more detail on the effectiveness of those actions when it produces the final report from the Neonatal Deep Dive exercise.

4.5 Future Monitoring and Reporting of Findings

It is anticipated that the final report from the exercise will be completed by the end of 2021. The report will draw together evidence from the various phases of the programme to provide a comprehensive appraisal of the current neonatal service. It will focus on safety and effectiveness, as well as identifying key areas for improvement and recommending actions to support both short and longer term solutions with an emphasis on clinically focused, measurable improvements the Health Board can implement and track. This will enable the service to demonstrate improvements in safety and ensure these are sustainable.

It is anticipated that the Minister for Health and Social Services will publish the final report once the work has been completed.

5 THE CLINICAL REVIEW PROGRAMME

When the Panel last reported in September 2020, the first phase of the Clinical Review Programme, which focused on mothers who required emergency care during childbirth, was nearing completion. Since that time, the second phase of the programme which examines the care provided to women and their babies who sadly were stillborn, has been concluded and the Panel's findings are being published alongside this report. A copy of the Thematic Stillbirth Category Report can be accessed here.

A detailed explanation of the programme is set out in the Panel's Clinical Review Strategy which can be accessed here. This was originally published in October 2019 and has since been revised to reflect more recent changes to the process. As such, this section does not repeat any process related information but instead provides an update on the current status of the individual elements of the programme.

5.1 THE 2016-2018 LOOK BACK

The Panel's clinical review work is currently focused on around 160 episodes of care provided by the Health Board between January 2016 and September 2018.[5] This includes the 43 incidents which were originally identified in the Royal Colleges' report. These episodes of care have been sub-divided into three categories which are set out in Figure 3 in the order in which the reviews are being undertaken.

Figure 3: *Clinical Review Categories*

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

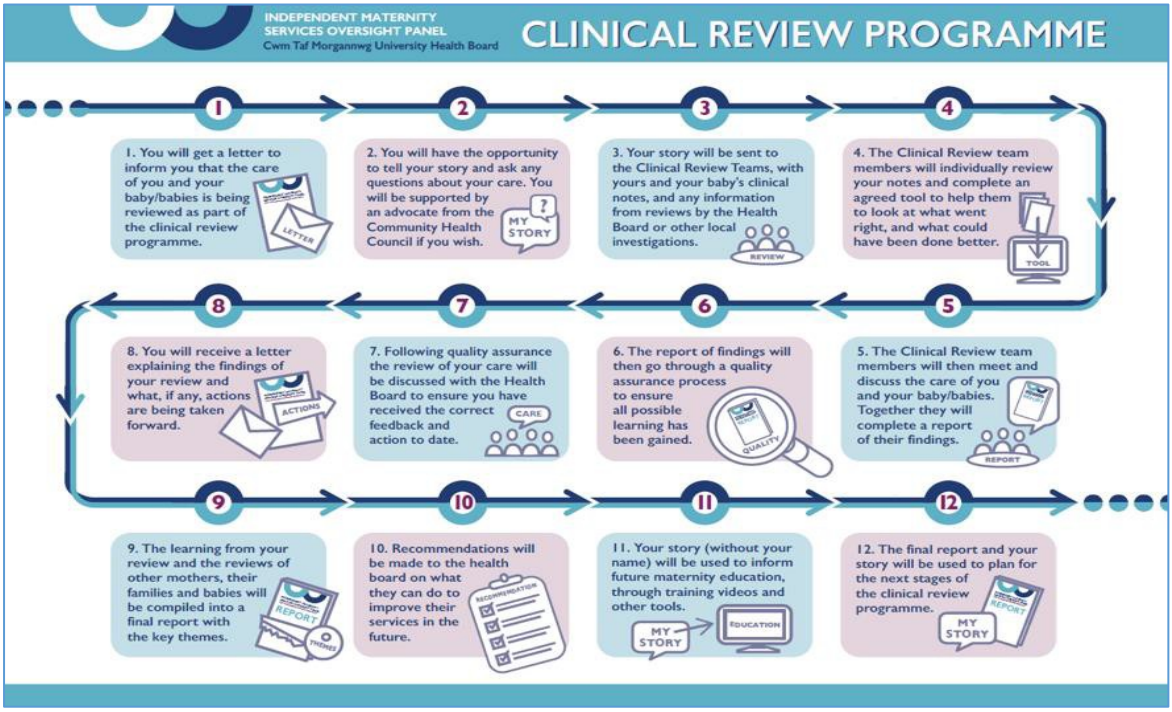
A pathway has been developed to explain to women and families the steps involved in the clinical review process. This is shown in Figure 4 and a larger version of the pathway is attached at *Appendix C*.

Additional information can also be found in the 'How We Did It' section of the Panel's second thematic report which can be accessed here.

Given the complexity of the clinical review process, it is still not possible to make accurate predictions regarding timescales for the completion of the full programme or to say precisely when all of the women and families involved will be made aware of the findings of their individual clinical review.

[5] *A small number of the self-referrals which have been included predate January 2016.*

Figure 4: *The Clinical Review Pathway*



However, as a broad indication of progress, Figure 5 indicates the current step on the clinical review pathway each of the three categories has reached. The steps indicated in the 'current status' column of the table are those described in Figure 4.

Figure 5: *Status of the Clinical Review categories*

CATEGORY	CURRENT STATUS
1. Maternal mortality and morbidity	Steps 11/12
2. Stillbirths	Steps 11/12
3. Neonatal mortality and morbidity	Steps 4/5/6/7

All women and families within the first two categories have now been contacted to confirm that their review is complete and that the findings are available should they wish to receive them.

In those instances where the findings have been requested, these have been shared with the women and families alongside an offer to meet with representatives from the Health Board or the Panel's Clinical Leads to discuss their findings in more detail, if they wish to. In addition, correspondence has been sent from the Health Board to acknowledge the findings and detail what action has or is going to be taken to address any issues identified in relation to their care.

In terms of next steps for the Panel, whilst it will continue to provide support and challenge to the Health Board's response to the outcomes from the stillbirth category, the focus has now shifted towards the neonatal mortality and morbidity category.

This involves the review of around 70 episodes of care provided between 01 January 2016 and 30 September 2018 where babies were admitted to the Health Board's neonatal units in Prince Charles and Royal Glamorgan Hospitals. Sadly, a number of those babies subsequently died or were transferred out for ongoing specialist care.

Not only is this another large cohort, the clinical aspects of these reviews are generally more complex than the previous category and will also examine the extent to which maternity and neonatal services worked together in an integrated way to provide care for mothers and their babies.

The current position is that around half of the episodes of care in the neonatal mortality and morbidity category have been assessed by the independent clinical review teams. Those which have been reviewed will now be validated and quality assured prior to the preparation of personalised feedback for women and families.

It is anticipated that the Panel will begin writing out to women and families early in 2022 to confirm that their clinical review is complete and their findings are available, should they wish to receive them. When all individual findings have been shared, the findings from the neonatal mortality and morbidity category will be reported upon by way of publication of a third thematic report.

Once the third and final category report in the 2016-18 Look Back is completed, an overarching report will be prepared and published summarising the cumulative learning from the three categories. It is still too early to make recommendations to the Minister about the necessity to undertake further reviews going back beyond 2016 and this will not be considered until the current element is close to completion.

5.2 SELF-REFERRALS

The Clinical Review Programme includes a process for reviewing episodes of care which have been self-referred by women and their families. A pathway has previously been prepared to explain the self-referral process to women and families and is attached at *Appendix D*.

To date, 25 self-referrals have been received by the Health Board.[6] All of these have been triaged and either included within the Panel's Clinical Review Programme or reviewed by the Health Board with oversight from the Panel's Clinical Leads.

All of the self-referrals received following the programme's commencement have now been concluded and correspondence has been sent by the Health Board to outline the findings and to detail any action to be taken, as well as to offer an opportunity to ask any further questions.

The self-referral process remains open for any women or families who have concerns about the maternity or neonatal care they received within the Health Board regardless of the time period in which the care was provided.

[6] *The 26 episodes of care involve 25 families.*

5.3 POST-OCTOBER 2018 SERIOUS INCIDENTS

When the Royal Colleges reported in April 2019, they identified significant concerns about the Health Board's processes for identifying, grading and investigating serious incidents. Root Cause Analysis was not well developed and there was little evidence that learning from serious incidents was shared or was being used systematically to improve safety and quality. Similarly, there was limited evidence that women and families were an integral part of the process.

Indeed, it was as a result of concerns about the way in which the Health Board recorded serious incidents that the Royal Colleges' review was initially commissioned. This resulted in a number of specific recommendations for improvements to the serious incident investigation process being included within the final report.

As identified in Section 7 of the Panel's Thematic Stillbirth Category Report, the Royal Colleges' concerns about the Health Board's processes for managing and responding to serious incidents were borne out to a significant extent by the findings of the stillbirth category of clinical reviews. Whilst this was not specifically identified as one of the key themes by the clinical review teams, it was a cross-cutting issue which emerged from the wider considerations of the Quality Assurance Panel.

When the Clinical Review Programme was originally developed, it was agreed that responsibility for managing post-October 2018 serious incident reviews would rest with the Health Board with oversight from the Panel. There were two reasons for that. The first and more pragmatic reason was the need to enable the Panel to focus on the 2016-18 Look-Back exercise which was a specific recommendation from the Royal Colleges. The second, more principle-based reason was that it was agreed that the Health Board should take responsibility for improving its own review processes and that was unlikely to happen if an independent external programme was developed to review more contemporaneous incidents.

On that basis, it was agreed that the Health Board would manage post-October 2018 serious incidents and the Panel would put in place a process to dip sample investigations at random, with a view to gaining the assurance necessary to advise the Minister that the processes currently in place are fit for purpose.

Over the past two years, a comprehensive package of measures has been put in place to improve incident reporting and investigation, not only in maternity and neonatal services, but more broadly across the Health Board. This has involved, amongst other measures:-

- a package of external support from the NHS (Wales) Delivery Unit;
- significant investment in Root Cause Analysis training;
- the development of new corporate policies and procedures;
- the introduction of standardised audit tools and reporting frameworks;
- improved central coordination and monitoring arrangements;
- support from peer networks to provide an element of independence.

In the early part of 2020, the Quality Assurance Panel dip sampled nine serious incident investigations as a means of gaining assurance about the quality and effectiveness of the Health Board's arrangements. Unfortunately, only two of the nine met the required standards and it was agreed that the Panel's assurance work would be suspended until the Health Board was confident that its processes would stand scrutiny.

A further assurance exercise was conducted in April 2021. This identified some significant improvements in the process however, the Panel was still unable to provide assurance that the overall process was fit for purpose and embedded in practice. It was also concerned that the backlog of incidents requiring investigation and sign off was increasing without a robust plan for expediting completion.

On that basis, the Panel escalated its concerns about the time it was taking to resolve this matter which resulted in a growing number of women and families awaiting a response from the Health Board, a delay in appropriate feedback being shared with staff to promote a just and learning culture and a delay in sharing crucial lessons learnt from the review of these incidents with clinicians, potentially affecting the Health Board's ability to learn from its previous mistakes.

In April 2021, the NHS (Wales) Delivery Unit was commissioned by the Welsh Government to support the Health Board with this work. The Delivery Unit have undertaken a specific piece of assurance work within maternity and neonatal services in the Health Board both to strengthen their processes and systems for incident investigations and learning from incidents, as well as to assist them in dealing with the backlog of serious incidents in a prioritised and timely manner.

The situation is being routinely monitored by the Board through the Quality and Safety Committee and the Maternity and Neonatal Improvement Board. Steady progress is now being made and the Panel is satisfied that there is a plan in place which should result in all historical serious incidents being fully investigated by November 2021.

At that point, supported by the Delivery Unit, the Health Board will then present a package of evidence to the Panel in order that it can seek the assurance it needs to sign off the Health Board's current serious incident investigation processes as fit for purpose. This will involve relooking at previously reviewed investigations and dip sampling a selection of others over the time period.

6 CONCLUSIONS AND NEXT STEPS

6.1 CONTEXT

This is the Panel's fifth report, which summarises the progress which the Health Board has made in delivering improvements in its maternity and neonatal services in the twelve months ending September 2021.

The report is comprehensive and hopefully self-explanatory and so the detail is not repeated. However, it may be helpful to draw out some of the key conclusions and judgements which are set out in the report.

The last twelve months have been incredibly challenging for the Health Board, for its senior leaders and their staff. It has also been challenging for the women and families who use the Health Board's services.

The second wave of COVID-19, which began to impact from October 2020 onwards, had a deeper and more debilitating impact on the Health Board's improvement programme than the first wave and it is important that this context is borne in mind when considering the progress which has been made.

When the Panel conducted an interim assessment of progress in February 2021, it concluded that as a direct result of the impact of COVID-19, the level of progress made had been limited and some things which the Panel and the Health Board had expected to be in place by that time were not. On that basis, with the Minister's permission, the progress report due in April 2021 was deferred for six months.

In April 2021, as the second wave of COVID-19 began to ease, a series of meetings were held between the Panel and the Health Board in order to 'reset and refocus' the improvement programme going forward.

Since that time, a series of measures have been put in place by the Health Board in order to re-invigorate the improvement programme and to regain the focus and momentum lost during the COVID-19 period. This includes the appointment of an experienced Programme Director, a fundamental redesign of the programme management framework and increased pace in addressing areas of risk, for example the management and investigation of post-2018 serious incidents.

A more detailed summary of these measures and their impact is set out in Section 2.

As a result of the 'reset and refocus', the Panel believes that having understandably lost momentum over the preceding 12 months, the Health Board's Maternity Improvement Programme is now 'back on the right track'.

6.2 ASSESSMENT OF PROGRESS

In preparation for the publication of this report, the Panel has drawn together and systematically evaluated information from a range of sources to provide an objective assessment of the progress which the Health Board is making.

The assessment process and the information which emerged from it is described in some detail in Section 2 of the report. However, the following broad conclusions can be drawn out:-

- given the impact of COVID-19, the pace of progress has been slower than the Panel or the Health Board would have hoped for;
- there has been regression in some areas, although where that is the case, the reasons for that are clear and there are plans and trajectories in place to recover the ground which has been lost;
- **whilst there is still work to do, the improvements which have been made in the maternity service over the last two and a half years have largely been consolidated and remain firmly embedded in operational practice**;
- some further incremental progress has been made and the Panel has agreed that there is sufficient evidence to justify another five of the 70 Royal Colleges' recommendations being signed off as fully delivered;
- **that brings the total number of recommendations now delivered to 55 and means that almost four-fifths (79%) have now been delivered.**

The Panel did not reach any firm conclusions about progress against the neonatal elements of the improvement plan because the Neonatal Deep Dive work is still in progress (although, as explained in Section 4, some concerns have been identified which were subsequently escalated to the Health Board and the Welsh Government).

The Panel and the Health Board have developed an Integrated Performance Assessment and Assurance Framework (IPAAF) to enable the Health Board's progress to be monitored over time. During August 2021, the Health Board conducted its third self-assessment against the IPAAF maturity matrices and concluded that:-

- **Safe and Effective Care** remains firmly in the **'Results'** phase with some aspects of the service approaching 'Maturity';
- **Quality of Women's Experience** is now firmly in the **'Results'** phase with many aspects of the service approaching 'Maturity';
- **Quality of Leadership and Management** is now firmly in the **'Results'** phase with some aspects of the service approaching 'Maturity'.

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

Although the gradings in each of the domains remains unchanged, there is evidence of progress, particularly in the Quality of Women's Experience and Quality of Leadership and Management domains which is exemplified in Section 2 the report.

In July 2021, the Panel spent three consecutive days in the Health Board, reviewing progress and looking for evidence that the improvements which have been made since the Royal Colleges' review were embedded in operational practice. The Panel visited the maternity and neonatal units at both Prince Charles and the Princess of Wales Hospitals, meeting with frontline staff, supervisors and managers.

This was the first opportunity to visit the hospitals and to meet face to face with staff since the onset of COVID-19 in March 2020. As such, it provided a valuable opportunity to take stock and to gauge the extent to which staff were engaged and committed to the improvement process. On the basis of the visit, the Panel concluded that:-

- although staff were clearly tired and operating under significant operational pressure, they were generally positive in their outlook;
- **there was an overriding sense of commitment at all levels and a genuine focus on the needs of service users**;
- there was a sense of measured confidence, particularly amongst managers, specialists and those involved directly in the improvement programme;
- whilst there is clearly pride in what has achieved to date, there is also a sense of realism about how much remains to be done;
- there was an increased feeling of openness and transparency and staff were as willing to talk about the problems they faced as well as their successes;
- there was more of a shared sense of direction than had previously been experienced, with key staff able to articulate future plans more clearly.

The Panel believes that the improvement process is now moving into a different and more complex phase which is moving beyond the Royal Colleges' recommendations. The reasons for this are discussed in more detail in Section 2.1 of the report.

The Health Board has also recognised the shift from the transactional to the transformational and is redeveloping its improvement programme around a series of work packages, a milestone plan which will change and evolve as the improvement journey progresses and a 'road map' which sets out the next steps in the improvement journey. This will ultimately lead to the development of a new five-year vision and strategy for the maternity and neonatal service towards the end of 2021.

This holistic and more dynamic approach is very much welcomed by the Panel. It will allow learning from the Clinical Review Programme, the Neonatal Deep Dive and the Health Board's continuous improvement work to be incorporated into the improvement plan as it emerges.

The Panel will work closely with the Health Board during the next period to develop a revised assessment framework and the outcome of those discussions will be reflected when the Panel next reports in March 2022.

6.3 Next Steps

In previous progress reports, the Panel has identified a series of next steps actions which were intended to provide a focus for the Heath Board during the next reporting period. This process has served a useful purpose to this point.

Given that the Health Board is now moving towards a more structured programme methodology, the Panel does not believe that it is necessary to create additional expectations beyond those which have already been agreed and built into the work packages and the milestone plans which form the basis of the improvement plan.

6.4 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.

7 LIST OF APPENDICES

Appendix A: Schedule of Recommendations Delivered

Appendix B: Schedule of Recommendations Requiring Follow-Up

Appendix C: Clinical Review Pathway

Appendix D: Self-Referral Pathway

Appendix E: Health Board Progress Against 'Next Steps' Actions

Schedule of Recommendations Delivered (September 2020 to September 2021)

In the current reporting period (September 2020 to September 2021), the Panel has assessed supporting evidence provided by the Health Board and verified a further five recommendations (derived directly from the Royal Colleges' report) which were signed-off internally by the Maternity and Neonatal Improvement Board.

In addition to the five recommendations delivered, the Panel considers there are an additional three recommendations which will also shortly be delivered in full. These will be reported against in the next reporting period (September 2021 to April 2022).

PROJECT WORKSTREAM: Quality of Leadership and Management				
Ref.	**Source**	**Recommendation**	**Date Verified**	**Follow-Up Required?**
7.39	RCOG	Review the working practice for how consultant cover for gynaecology services will be delivered after the merger. A risk assessment must be performed to determine the case mix of planned surgery on the Royal Glamorgan site when there is no resident gynaecology cover.	22 February 2021	The Panel will review the recommendation again in six months' time in order to ensure that the systems which are in place are embedded within the new ILG framework and fully operating post COVID-19.
7.42	RCOG	In conjunction with Organisation Development, undertake work with all grades of staff around communication, mutual respect and professional behaviours. Staff must be held to account for poor behaviours and understand how this impacts on women's safety and outcomes.	22 February 2021	There is no planned follow-up for this recommendation. The Panel expect the Health Board to continually monitor all completed recommendations to ensure there is no regression.
7.69	RCOG	Identify and nurture the local leadership talent.	22 February 2021	There is no planned follow-up for this recommendation. The Panel expects the Health Board to continually monitor all completed recommendations to ensure there is no regression.

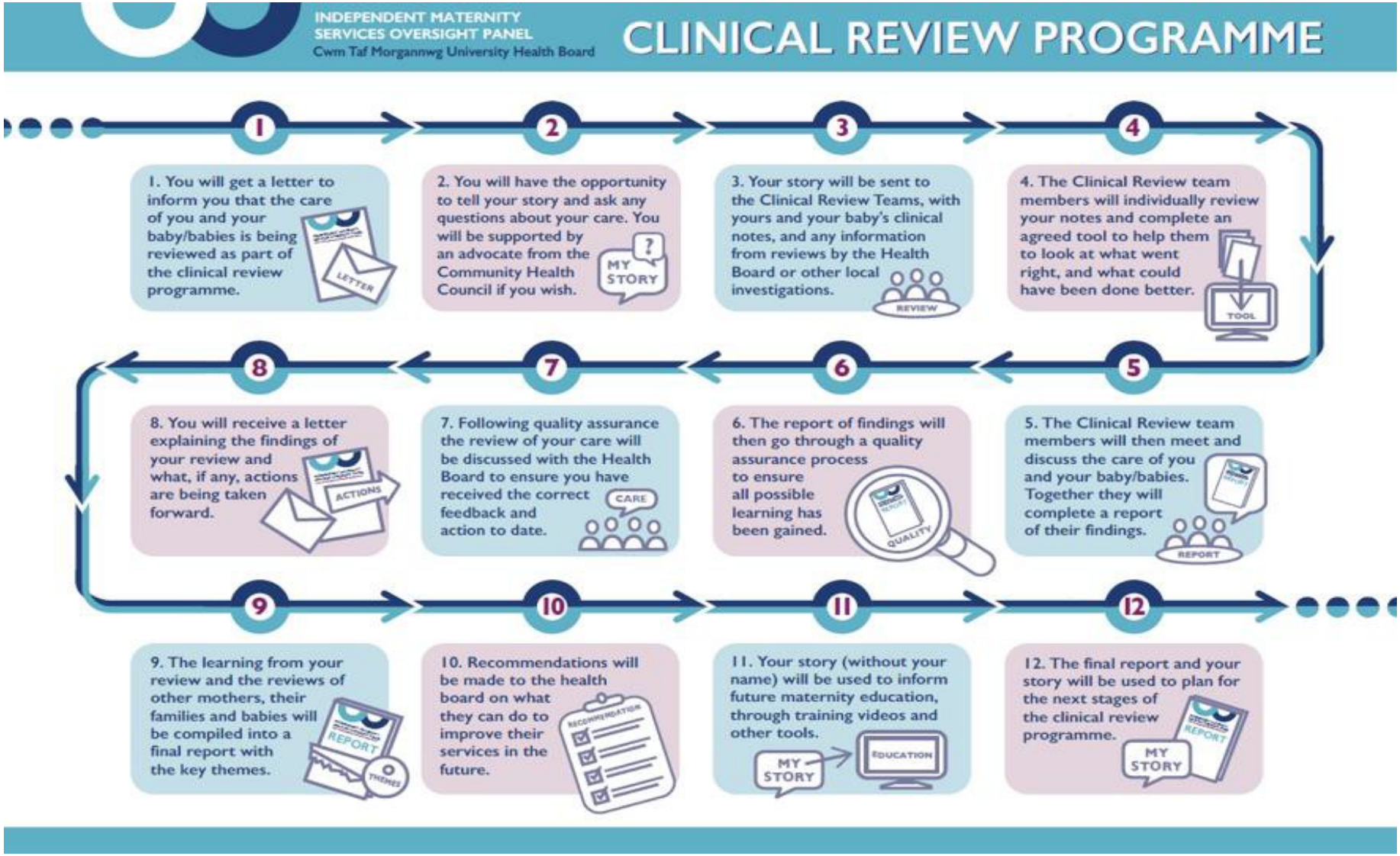
PROJECT WORKSTREAM: Quality of Women's Experience				
Ref.	**Source**	**Recommendation**	**Date Verified**	**Follow-Up Required?**
7.53	RCOG	Communications, support and engagement approach and strategy to demonstrate openness, honesty and transparency and not solely focus on management of key messages.	03 September 2021	There is no planned follow-up for this recommendation. The Panel expects the Health Board to continually monitor all completed recommendations to ensure there is no regression.
7.54	RCOG	Prioritise an engagement programme with families at its heart. Women and families affected by events should be part of the improvement, co-design and culture change of the new service.	02 August 2021	The Panel will review the recommendation again in six months' time in order to ensure that momentum has been maintained and the foundations which have been created thus far are maintained and built upon further.

Schedule of Recommendations Requiring Follow-Up (September 2020 to September 2021)

In the current reporting period (September 2020 to September 2021), the Panel has reassessed additional evidence provided by the Health Board relating to 21 recommendations, derived directly from the Royal Colleges' report, which have previously been delivered in terms of actions. It has been determined that 10 recommendations will be followed up within the next reporting period to ensure improvements are being embedded in practice and having a positive impact on the outcomes for women, babies and families.

PROJECT WORKSTREAM: Quality of Leadership and Management			**PROJECT WORKSTREAM: Safe and Effective Care**		
Ref.	**Source**	**Recommendation**	**Ref.**	**Source**	**Recommendation**
7.05	RCOG	CTG training programme.	**7.23**	RCOG	Sharing the outcomes from SI's on a regular basis and in an appropriate, regular and accessible format to improve learning.
7.18	RCOG	Methods of consultant working following merger.	**7.27**	RCOG	Extra resource to the Maternity Governance and Risk team to allow a timely reviews.
7.22	RCOG	Actively discuss the outcomes of SI's in consultant appraisals.	**7.36**	RCOG	Clinical supervision and consultant oversight of practical procedures must be in place for all staff (including specialist midwives and staff doctors).
7.30	RCOG	Medical director has effective oversight and management of consultant body.			
7.32	RCOG	Obstetric consultant cover.			
7.37	RCOG	Department-wide MDT teaching programme.			
7.40	RCOG	Skills and competencies for extended practice roles.			

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

Appendix E

Health Board Progress Against Next Step Actions Arising from Autumn 2020 Progress Report

	Action	Status	Evidence of Progress
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.	Complete	The Panel's first thematic report was published in January 2021. The Health Board developed a comprehensive public, media and stakeholder communications response which was overseen by the Executive Team and the Board. A comprehensive package of support was also put in place for women, families and staff. This is now being built on for the publication of the second thematic report.
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.	Complete	A standard operating procedure on risk mitigation was developed in June 2021. Recovery trajectories have been delivered for key activities which were impacted on by COVID-19 and the Health Board has evidenced good progress against these trajectories, for example, the delivery of PROMPT (Practical Obstetric Multi-Professional Training). COVID-19 risk is directly managed within the improvement programme risk register. This is managed through the Maternity and Neonatal Improvement Board.
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.	Work in Progress	In March 2021, the Health Board appointed a Programme Director with a track record of managing complex change and transformation programmes. Since then, the programme management arrangements have been fundamentally redesigned based around a series of work packages, a milestone plan and a road map which will lead to the development of a longer-term vision and strategy. Within that the milestone plan will provide clear timescales and deliverables and be linked where appropriate to outcomes and metrics. During the next period the Panel and the Health Board will redevelop the arrangements for monitoring and evaluating progress based on the revised arrangements. Further information is contained in Section 2.10 of the report.

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.	Complete	A workshop was held in December 2020 involving the Panel, the Health Board and the Welsh Government. Agreement was reached in terms of how the IPAAF will be developed going forward. Unfortunately, the developments which were agreed have not yet been implemented due to the impact of COVID-19. However, a review of the IPAAF is included within the MNIB work programme for October 2021. Although the development work remains to be done, the action related to the holding of a workshop and as such, the action has been recorded as completed.
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.	Complete	The Health Board has established two new Women and Children's Health (WCH) Services Clinical Service Groups in Merthyr Cynon and Bridgend Integrated Locality Groups (ILGs), effective from the 01 April 2021. This brings neonatal and maternity services together into a single directorate. The transition into the ILG framework is still work-in-progress however, the action related to the identification of a longer term solution and in that respect, the action is considered to be completed.
6.	**Engagement Cycle** - The Panel believes that the Engagement Cycle process map is an important development which should be progressed at the earliest opportunity.	Complete	The Engagement plan 2020-2023 was drafted, finalised and shared with Maternity Improvement Board in November/December 2020. The plan encompasses the multiple methodologies that the service currently has in place in order to engage with service users and capture feedback, in addition to other methodologies which the service commits to putting into place in the near future. The engagement cycle process map is integral to the strategy.
7.	**Development of PREMs** - the Panel believes that PREMs is an important development which the Health Board should progress at the earliest opportunity**.**	Complete	The Civica system went live in August 2021 and the maternity user surveys have been built. There is work ongoing to structure data and establish connections to different capture devices (e.g. iPads). It is anticipated that this work will be complete by the end of September. Further information about the roll out of the PREMs process is set out in Section 3 of the report.

8.	**Complaints and Concerns** - the Panel will continue to monitor how the Health Board responds to recurrent themes from complaints and concerns.	Work in Progress	The responsibility for the management of complaints and concerns now rests with the ILG's. Performance data is captured monthly through this mechanism. There have been some early challenges in the transition from the service led model to the ILG framework and the Panel will monitor the situation over coming months to ensure that the revised arrangements are bedding in. Further information is provided in Section 3 of the report.
9.	**Communicating Progress** - the Health Board should develop a process for communicating the progress of its maternity services improvement work at the earliest opportunity.	Complete	The organisation's approach to communications and engagement has moved on substantially over the past twelve months following the appointment of an Assistant Director of Communications and Engagement and a fundamental review of the organisation's capacity and capability. This is reflected in the sign-off of 7.53 of the Royal Colleges' recommendations. Dedicated communications staff have been recruited and multiple communication channels have and continue to be developed. The maternity service website will go live at the end of September 2021.
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.	Work in Progress	The NHS (Wales) Delivery Unit (DU) is supporting the maternity and neonatal services in achieving the outstanding areas of improvement needed within their incident management processes. A significant milestone has been the establishment of an agreed, inclusive list of open incidents within both maternity and neonatal services from October 2018. The corporate team are working closely with maternity and neonatal service leads, in addition to the ILG governance teams, to progress the cases at pace. Multidisciplinary Closure and Assurance Panels have been set up by the central team to convene on a fortnightly basis to consider between 6-10 completed incidents for closure, quality assurance and consideration of further action. The first panel was held on 30 July 2021 and three learning events were held on 02 August 2021. Further information is contained within Section 5 of the report.

8 GLOSSARY OF TERMS

A&E	Accident and Emergency Department
AMU	Alongside midwifery led unit
ANNP	Advanced Neonatal Nurse Practitioner
Apgar	A scoring method used to assess the condition of baby' at birth
AW	Audit Wales
Badgernet	Neonatal patient data management system
BP	Blood pressure
BR+	Birthrate plus
CD	Clinical Director
CEO	Chief Executive Officer
CHC	Community Health Council
CLC	Consultant Led Care
CMB	Clinical board meeting
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COO	Chief Operating Officer
CPAP	Continuous Positive Airway Pressure
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
DOM	Director of Midwifery
DON	Director of Nursing
DU	NHS Wales Delivery Unit
EBC	Each Baby Counts
EFM	Electronic fetal monitoring
ELCS	Elective caesarean section
EMCS	Emergency caesarean section
ETT	Endotracheal tube
Euroking	National maternity IT system
FGR	Fetal growth restriction
FMU	Freestanding Midwifery Unit
GAP	Growth assessment protocol
GMC	General Medical Council
GP	General Practitioner
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
HM Coroner	Her Majesty's Coroner
HOM	Head of Midwifery
HOMAG	The All Wales Heads of Midwifery Advisory Group
HR	Human resources
HSCSC	Health, Social Care & Sport Committee
HSIB	Healthcare Safety Investigation Branch
HTA	Human Tissue Authority
IA	Intermittent Auscultation
ICU	Intensive Care Unit
ILG	Integrated Locality Group
IMSOP	Independent Maternity Services Oversight Panel
IOL	Induction of labour
IPAAF	Integrated Performance Assessment and Assurance Framework
IPPV	Intermittent Positive Pressure Ventilation
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
MID	Maternity Improvement Director
MITs	Maternity Information Technology System (feeds into QlikSense)
MLC	Midwifery led care
MLU	Midwifery led unit
MMMW	My Maternity My Way (the redeveloped MSLC for CTMUHB)
MNIB	Maternity and Neonatal Improvement Board
MNIP	Maternity and Neonatal Improvement Plan
MNIT	Maternity and Neonatal Improvement Team
MPB	Maternity Performance Board
MS	Member of the Senedd
MSLC	Maternity Services Liaison Committee
MVF	Maternity Voices Forum
NBC Pathway	National Bereavement Care Pathway
NEWTT	Neonatal early warning track and trigger
NICU	Neonatal intensive care unit
NMC	Nursing and Midwifery Council
NMPA	National Maternity and Perinatal Audit
NNAP	National Neonatal Audit Programme
NNU	Neonatal Unit
O2	Oxygen
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
PMRT	Perinatal Mortality Review Tool
POW	Princess of Wales Hospital
PREMs	Patient Reported Experience Measures
PROMPT	Practical Obstetric Multi-Professional training
PROMS	Patient Reported Outcome Measures
PSAG	Patient status at a glance
PSOW	Public Service Ombudsman for Wales
PTR	Putting Things Right
Q&SC	Quality and Safety Committee
QA	Quality assurance
QlikSense	Business intelligence and visual analytic software
RCA	Root cause analysis
RCoA	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
SANDS	Stillbirth and Neonatal Death Society
SB	Stillbirth
SBAR	Acronym for situation, background, assessment and recommendation
SCBU	Special care baby unit
SCU	Special care unit
SFH	Symphysis fundal height
SFSP	Secure file sharing portal
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
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
WESEE	Operational meetings which cover Workforce, Effectiveness, Safety and Experience and Engagement
WMNN	Wales Maternity and Neonatal Network
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.