INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL

Cwm Taf Morgannwg University Health Board

Progress Report
April 2022

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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. This report, the sixth progress report to be published to date, covers the six-month period to 31 March 2022. It summarises the further progress which the Health Board has made in improving its maternity and neonatal services as well as providing an update on 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 Minister is also publishing the third in a series of thematic reports arising from the Panel's Clinical Review Programme. The report, which examines the care of mothers and their babies who sadly died or required specialist neonatal care following birth, can be accessed on the Welsh Government's 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 27 years' experience as a Consultant Obstetrician and has recently completed his post as the National Clinical Lead in Obstetrics for the Scottish Maternity and Children Quality Improvement Collaborative. He is a clinical advisor for the Healthcare Safety Investigation Branch.

Christine Bell (Midwifery Lead) has over 31 years' experience working as a Midwife in England, ten of those as a Head of Midwifery in a large NHS Trust. She has extensive experience in change management and service transformation.

Kelly Harvey (Neonatal Nursing Lead) has over 19 years' experience as a Neonatal Nurse and Advanced Neonatal Nurse Practitioner and is currently Senior Nurse for the North West Neonatal Network. She is also a member of the National Neonatal Nurses Association Executive Committee.

Alan Fenton (Neonatologist Lead) has over 27 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.

Executive Summary

When the Panel last reported in September 2021, it advised that despite the ongoing challenges of the COVID-19 pandemic, in relation to the maternity service, the Health Board was making good progress in addressing the recommendations for improvement which were set out in the Royal Colleges' report. However, there was still work to be done, particularly in addressing some of the longer-term development needs related to organisational culture, leadership, vision and strategy.

The Panel also highlighted that the nature of the Health Board's improvement journey was changing, moving away from a focus on systems and process towards a longer-term transformational approach designed to ensure that the service is fit for purpose and sustainable in the longer term.

The Panel advised that this would require some adjustments to the way in which it assesses the Health Board's progress, moving away from the Royal Colleges' recommendations as the primary indicator towards a wider, more holistic approach, based on assessing progress against a milestone plan, a 'road-map' and a five-year vision and strategy which is being developed with the engagement of staff, stakeholders and service users.

However, at that time some issues had been identified in relation to the neonatal service at Prince Charles Hospital which had resulted in a 'deep-dive' review being commissioned in collaboration with the Health Board. At that time, the review had been commenced and some early issues had been identified which had the potential to impact on the safety of the service and these had been escalated to the Health Board and the Welsh Government for immediate action.

Over the last six months, the Health Board has continued to make further incremental progress in relation to its maternity service and the programme management arrangements which have been put in place to support the wider improvement process have been further strengthened.

There has also been reassuring progress in relation to the quality of the oversight and scrutiny which is provided to maternity and neonatal services by the Board via the Quality and Safety Committee. Some significant milestones have also been delivered including the successful completion of the programme of work being done with the support of the NHS (Wales) Delivery Unit to improve the Health Board's processes for investigating and learning from serious incidents.

At the end of February, the Panel conducted an 'assurance visit' across the three Health Board sites, meeting face to face with staff and senior managers and reviewing evidence of further progress. All six Panel members were involved, providing the opportunity to look in some depth at the current position. This included visits to wards and observations of key activities including handovers and ward rounds.

The outcomes of the assurance visit are set out in more detail in Section 2.2 of the report but in summary, the visit provided clear indications that the improvements which have been made in the maternity service over the last three years have been consolidated and are now increasingly embedded in practice.

The assurance visit also identified that further progress had been made against a number of the remaining Royal Colleges' recommendations and the stage has now been reached where the Panel believes that the original Royal Colleges' action plan is almost ready for closure. There are still some legacy actions which need to be taken forward and some of those are significant in nature; however, those issues can now be reflected more appropriately in the milestone plan which has been developed to support the delivery of the longer-term improvement of the service.

In collaboration with the Health Board and the Welsh Government, the Panel has developed an Integrated Performance and Assessment and Assurance Framework (IPAAF) which uses a series of matrices in order to report the Health Board's self-assessment of services over time.

The framework uses both qualitative and quantitative information to consider the Health Board's progress against a series of descriptors and five levels of progress ranging from basic, through early progress and results to maturity and exemplar status. Maturity, which is the Health Board's current aspiration, describes a service which is broadly performing to expectations, albeit with some ongoing development needs.

In recent months the IPAAF process has evolved to place greater emphasis on the Health Board self-assessing its own progress against the maturity matrices with the Panel reviewing the assessment and supporting where appropriate.

In April 2022, the Health Board conducted a self-assessment against the IPAAF and concluded that in relation to the 'Safe and Effective Care' and 'Quality of Women's Experience' domains, the maternity service had reached 'Maturity', whilst the 'Quality of Leadership and Management' domain remained in 'Results' albeit moving towards 'Maturity'. In relation to the neonatal service, the Health Board concluded that the service was making 'Early Progress' in all three domains.

The Panel has reviewed the Health Board's self-assessment and agrees that this is a reasonable and objectively derived assessment of the current position. The results of the self-assessment will be formally presented to the Board at its public meeting in May and as such are subject to ratification.

The shift from 'Results' to 'Maturity' in the Safe and Effective Care and Quality of Women's Experience domains is a significant milestone for the Health Board in relation to its maternity services. In simple terms, this indicates that the service is now broadly being delivered to the standards which are expected of a maternity service operating at this level within the UK health system.

That does not mean that there is not more work to do; indeed, every service has ongoing development needs. However, it does indicate that the Health Board is now comparable to others in Wales in those specific domains and in some areas, particularly in respect of some aspects of its work in engaging with women and families, it may now actually be setting standards for others to follow.

The fact that the maturity assessment for the neonatal service remains at “Early Progress’ in all three domains is a reflection that the service is at a very different stage in its improvement journey than the maternity service.

The Panel acknowledges that there have been positive developments in all of the 19 areas identified by the neonatal deep-dive review as requiring immediate action, with preparatory work completed and some early results generated. However, the Panel has concluded that only five of the 19 areas for immediate improvement can be considered as fully completed and embedded in practice at this time.

The Panel had hoped that by this time, more evidence would have been seen of tangible progress against the recommendations emerging from the deep-dive review and in particular those requiring more immediate action. That said, the Panel acknowledges that there have been significant and sustained operational challenges within the neonatal service over the past six to eight months which have impacted on the capacity of the service to free up staff to engage in improvement activities.

The Panel’s concerns about the pace of progress have been raised and indeed are shared by the Health Board. They have been received constructively and there is a commitment to increase the pace of delivery in the coming months as additional capacity becomes available.

Given the sustained progress which is now being made, the Panel believes that if the situation evolves as anticipated over the next six months, the Panel should be in a position when it next reports in September 2022 to provide the Minister with an assessment of whether it believes that the Health Board’s improvement journey is sustainable. That will then enable the Minister, should she so wish, to consider what is necessary in terms of continued external oversight going forward.

As previously noted, the maternity and neonatal services’ improvement journeys are at different stages, due in large part to the initial focus on those ‘make safe’ areas within maternity services identified by the Royal Colleges. It is therefore unlikely that all of the work needed to improve the neonatal service to the required standard will be completed within the next six months. It is also evident from the neonatal deep-dive that a number of the required improvements will take considerable time to demonstrate successful outcomes.

That said, the Panel believes that sufficient meaningful progress can be made by the Autumn if the approach which has been applied successfully by the Health Board to improve its maternity service is applied to the neonatal service. It also believes that the neonatal deep-dive action plan created to support the Health Board in taking forward the necessary improvements provides clear guidance on what would need to be in place for any outstanding areas to be verified through any future assessment.

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1 The Journey So Far

1.1 The September 2021 Position

When the Panel last reported in September 2021, it concluded that despite the ongoing challenges of the COVID-19 pandemic, in relation to its maternity services, the Health Board was making good progress in addressing the recommendations for improvement which were set out in the Royal Colleges' report.

At that time, 55 of the 70 Royal Colleges' recommendations had been delivered, although ten required ongoing monitoring to ensure that the improvements which had been made were embedded in practice and continued to have a positive impact.

Whilst acknowledging that significant progress had been made, the Panel emphasised that the recommendations which had been delivered by the maternity service to that point had been largely transactional in nature; most related to improvements in the systems, processes and procedures which needed to be put in place to ensure that the service provided is safe and effective, well led, well managed and focused on the needs of service users.

The Panel advised that further work was needed to make those improvements sustainable and this would require a shift to a more transformational approach, particularly to address some of the more challenging, longer-term development needs associated with organisational culture, leadership and strategy.

The Panel also explained that due to the way in which the Maternity and Neonatal Improvement Programme was evolving, some adjustments would be needed to how the Health Board's progress was assessed. This required moving away from the Royal Colleges' recommendations as the primary indicator of progress towards a wider, more holistic approach based on assessing progress through monthly highlight reports against a milestone plan, a 'road-map' and the jointly agreed Integrated Performance Assurance and Assessment Framework (IPAAF).

At that time, the Health Board's self-assessment of progress against the IPAAF indicated that all three of the maternity domains (Safe and Effective Care, Quality of Women's Experience, and Quality of Leadership and Management) were firmly in the 'Results' phase with a number of aspects approaching 'Maturity'. The Panel had reviewed that assessment and fully supported the Health Board's conclusions.

An IPAAF self-assessment was not completed for the neonatal service at that time because the neonatal deep-dive review, which had been commissioned jointly by the Panel and the Health Board earlier that year, had not been fully completed.

However, the Panel did provide an update on the progress of the deep-dive review when it last reported and highlighted that some issues had been identified in relation to Prince Charles Hospital's neonatal service which had the potential to impact on safety. These had been escalated to the Health Board and the Welsh Government for immediate action and the Health Board was taking steps to address them.

In the intervening period, the neonatal deep-dive review has been completed and a report setting out the Panel's findings and recommendations was published by the Minister in February 2022. The report can be accessed here.

Further detail on the early progress which is being made in improving neonatal services can be found in Section 3.

In previous progress reports, the Panel identified a series of next steps actions to provide a focus for the Heath Board during the subsequent reporting period. Given that the Health Board had developed a more structured programme management approach, when it reported in September 2021, the Panel advised that it was no longer necessary to create additional expectations beyond those already agreed and built into the Health Board's milestone plan.

1.2 Putting the Current Reporting Period into Context

Whilst the direct impact of the COVID-19 pandemic may not have appeared as significant during the current reporting period as it was during the previous 18 months, it is important to recognise the continued operational pressures faced by the Health Board, particularly in terms of delivering its vaccination programme, establishing its COVID-19 recovery programme and responding to the ongoing demands on its frontline services through a difficult and prolonged winter period.

COVID-19 related sickness absence has also continued to significantly impact on the pace of progress in delivering the Health Board's improvements plans; there have been occasions over the last six months when it has been necessary to return staff involved in improvement activities back to frontline duties to support their operational colleagues. This has been particularly so within the neonatal service, which has been hit hard by short term sickness absence.

Despite those challenges, supported by the dedicated improvement teams, the Health Board's frontline clinicians, operational managers and senior leaders have remained focused and engaged in driving forward improvements in maternity and neonatal services. At the same time, the Health Board's Quality and Safety Committee has continued to provide scrutiny and challenge to the Maternity and Neonatal Improvement Programme, ensuring increasingly effective Board level oversight of the improvement journey.

For the most part, the Panel has continued to work in a virtual capacity. However, a three-day on-site assurance visit was conducted at the end of February 2022. This involved all six Panel members and provided a timely opportunity to examine the current position in some depth. The assurance visit included face to face meetings with frontline staff and operational managers, visits to wards in the Health Board's three hospital sites and observations of key activities such as handovers, ward rounds and training sessions.

The outcome of the on-site visit and detailed information about the Panel's current assessment of progress can be found within Section 2.

Unfortunately, due to ongoing COVID-19 restrictions within the clinical environment, it was not possible for the Panel to meet with service users during the site visits. However, the Panel's Lay Member has continued to actively engage with the My Maternity My Way Forum and support the development and implementation of the maternity and neonatal engagement and communication strategies.

Additional information about the Health Board's approach to engaging with women and families can be found in Section 5.

The delivery of the Panel's Clinical Review Programme, which is predominately exploring the maternity and neonatal care provided by the former Cwm Taf University Health Board between 01 January 2016 and 30 September 2018, has continued in this reporting period.

Alongside this report, the Panel is publishing its Thematic Neonatal Category Report which examines the care of mothers and their babies who sadly died or needed specialist neonatal care following birth.

Further information on the Clinical Review Programme, including the Health Board's management of serious incident reviews, can be found in Section 4.

1.3 Focus on Sustainability

The Panel's last progress report emphasised that the nature of the Health Board's improvement journey was changing, moving away from a focus on systems and process towards a longer-term transformational approach designed ensure to that the services provided are fit for purpose and sustainable. At the same time, there has been a shift towards the Health Board taking more direct control over the direction of the improvement journey and ensuring that the programme is increasingly owned by frontline staff and integrated into day-to-day service delivery.

In consultation with the Welsh Government and the Health Board, the Panel has now agreed a set of conditions or circumstances which will, when they are achieved, provide a reasonable degree of assurance that the improvements which the Health Board continues to make are sustainable in the longer term.

These 'conditions for sustainability' are closely aligned to the Health Board's milestone plan and the Panel believes that if the plan is delivered as intended and to the timescales prescribed, the majority of the conditions should be in place within the next six to nine months. This should enable a transition to a more 'business as usual' approach within maternity and neonatal services by the time the Panel next reports in September 2022. It should also enable the Panel to provide advice to the Minister about the extent to which continued external oversight is necessary.

The conditions for sustainability are discussed in Section 6. However, throughout this report they have been emphasised in purple boxes aligned to the areas of work they relate to.

2 Assessment of the Health Board's Progress

In preparation for the publication of this report, the Panel has drawn together information from a range of sources to provide an objective assessment of the Health Board's progress over the past six months and more broadly in the three years since the Royal Colleges' report was published. The key sources of information include:-

- reviews of documentary evidence;
- observation of operational and governance related meetings;
- staff engagement;
- on-site assurance visits;
- talking to women and families;
- improvement showcases;
- the Health Board's self-assessment against the IPAAF.

This evidence has been evaluated and triangulated against other information sources provided by external stakeholders and the Panel's conclusions are set out in the following paragraphs.

2.1 Maternity and Neonatal Improvement Plans

Over the last 18 months, there has been considerable enhancement of the Health Board's programme management arrangements which are now led by a dedicated Programme Director with extensive experience of managing transformational change programmes at a corporate level. As a result, there is now a sustained focus on outcomes and deliverables, with plans centred on longer-term sustainable improvement, supported by clearly articulated timescales.

The Health Board's 'roadmap' for maternity and neonatal service improvement can be found at Appendix D. This provides an overview of the improvement journey and highlights the transition from an improvement team-led approach to one which will increasingly become embedded in normal operational structures.

The milestones which the Health Board aims to achieve are set out against the three domains described in the IPAAF: (i) Safe and Effective Care; (ii) Quality of Women's Experience; and (iii) Quality of Leadership and Management. Each domain has a designated lead who reports through to the Improvement Director.

A number of significant milestones have been achieved during this reporting period, some examples of which are as follows:-

- a Maternity and Neonatal Assurance Framework has been developed and approved as a working draft, explaining how issues are escalated from 'floor to Board' and demonstrating how communication flows through each level of the governance structure;

- a staff culture survey has been completed and the feedback which emerged has been used to shape a Culture and Leadership Development Programme which will begin to be rolled out across the service in the next period;
- service user and staff engagement events have taken place, the feedback from which has been analysed and themes extracted to support the further development of the Maternity Vision;
- an interactive public and internal facing maternity services webpage has been launched, enabling more effective communication with staff and clear information for potential service users.

In addition to those developments, the Health Board remains on track to complete a number of other important milestones over the next four to six weeks which the Panel believes will sustain momentum within the improvement programme going forward. This includes:-

- the development of a first iteration of the maternity data 'dashboard' which provides key information about the quality and safety of the service;
- the establishment of a Quality Improvement (QI) approach and an associated plan to take this forward jointly across maternity and neonatal services;
- the development of an engagement and experience dashboard;
- completion of a culture and development leadership plan.

There is now a clear focus within the Health Board's plans on moving beyond the Royal Colleges' recommendations to a more dynamic, continuous improvement approach which uses a Quality Improvement (QI) methodology to incrementally deliver change which is both measurable and sustainable.

Condition for Sustainability – Quality Improvement (QI)

A QI approach is in place, aligned to the corporate iCTM arrangement; QI plan and active QI projects are in place with evidence that small scale incremental changes are being delivered.

There is now a robust Health Board-led process in place for managing the maternity and neonatal improvement process. Completion (or non-completion) of key milestones is reported via the Maternity and Neonatal Improvement Board (MNIB) through to the Quality and Safety Committee (Q&SC).

Programme level risks and metrics are also reported through this mechanism. This enables the organisation to maintain clear oversight of how the improvement programme is functioning, what remains to be done and what challenges may be faced within the coming weeks. Although trending downwards, the most significant risk remains the delay in progress and/or the delay in the Panel gaining assurance of progress due to the COVID-19 response.

The Panel believes that the current programme management structures are an essential tool which will enable the Health Board to ensure that the improvements which are being delivered are sustainable in the longer term.

Condition for Sustainability – Programme Management

Effective programme management structure is in place, which defines the objectives of the improvement work, has plans which show how the work is delivered and what barriers could impact on delivery or outcomes; structure has effective, open and transparent reporting, with effective Board oversight.

Over the past six months, the Panel has observed a number of Q&SC meetings and has seen significant improvements in the quality and accuracy of papers associated with the Maternity and Neonatal Improvement Programme. Moreover, the quality of the challenge and scrutiny now provided by Independent Members has offered further assurance that an appropriate level of corporate oversight is now in place.

This will be a key factor in ensuring that the improvements which are being made will be embedded in practice and sustainable in the longer term.

Condition for Sustainability – Corporate Governance

Effective oversight and scrutiny of current maternity and neonatal service provision consistently being provided by the Board and the Quality and Safety Committee.

2.2 Assurance Visit

At the end of February 2022, the Panel completed a three-day ‘assurance visit’ to the Health Board, building on a similar exercise conducted in July 2021. However, on this occasion, due to the recent relaxation of COVID-19 restrictions, all six Panel members were able to attend in person and visits were made to all three sites, including the Prince Charles, Princess of Wales and Royal Glamorgan Hospitals.

The visit enabled the Panel to assess what further progress had been made in the intervening nine months and to confirm whether the Health Board’s reported improvements over the last two years had been delivered ‘on the ground’. It also helped to maintain the Panel’s visibility and frontline staff had the opportunity to engage and share their views on the service if they wished to.

The assurance visit also provided a valuable opportunity to review the Health Board’s progress in terms of delivering against the outstanding Royal Colleges’ recommendations. Similarly, it provided the opportunity for the Panel’s neonatal leads to visit the Prince Charles Hospital (PCH) and Princess of Wales Hospital (POW) neonatal units for the first time and engage directly with frontline staff.

This enabled the Panel to gain a first-hand understanding of the early progress which has been made against the neonatal deep-dive recommendations, as well as fostering relationships with clinicians and service managers which will support the continued delivery of the Panel's suggested minimal interventions going forward.

The assurance visit was Health Board-led and designed to demonstrate evidence of progress against those Royal Colleges' recommendations which had not yet been verified by the Panel or required further follow-up, as well as to showcase early progress in addressing the recommendations emerging from the neonatal deep-dive review. The programme included individual and group conversations, observations, ward walk-arounds and drop-in sessions.

The assurance visit was a hugely valuable and informative exercise which enabled the Panel to conclude that:-

- the progress which was seen during the previous visit in July 2021 has been consolidated and built upon;
- further progress has been made in the maternity service, albeit that managers and frontline staff acknowledged that there is still more to be done;
- the majority of the staff with whom the Panel met were committed, enthusiastic and demonstrated an appetite for improvement and change;
- there is an emerging and shared sense of strategic direction - key individuals are now able to articulate future improvement plans more clearly than before and to explain how the improvement programme is increasingly becoming 'business as usual';
- staff at the PCH and POW sites are starting to work more effectively together and there is clear evidence that they are learning from each other;
- as a result, services are becoming more consistent across the different sites.

The visit also provided assurance or further assurance in a number of key areas within maternity services, including bereavement care, clinical handovers, debriefing services and consultant job planning. There was also some assurance obtained in key areas within the neonatal service such as consultant cover, joint audit planning and the development of a clinical dashboard.

Further information about the early progress which has been made in responding to the issues which emerged from the neonatal deep-dive can be found in Section 3.

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

- there is still more work to be done to better integrate maternity and neonatal services to deliver seamless care for mothers and babies;
- issues remain regarding babies being born outwith the PCH neonatal unit's criteria and this should be a priority for the joint senior leadership teams;

- further information is required to understand how concerns and complaints are being managed, particularly as the Health Board has since announced changes to its current Integrated Locality Group (ILG) operating model (see Section 2.4);
- there needs to be more meaningful progress to achieve current aspirations for a data driven approach to governance and assurance, for example through the development of data dashboards;
- sharing learning from POW may accelerate the pace of improvements delivered within both maternity and neonatal services at PCH;
- the long-awaited establishment of the Gynaecology Assessment Unit at PCH represents a valuable opportunity for staff and service user engagement.

The feedback from the visit was positively received by the Health Board and is being reflected in their improvement plans going forward.

2.3 Staff Engagement

During the three-day visit, the Panel met with staff at all levels and in a variety of different roles, both as individuals and in larger focus groups. This provided a valuable opportunity to understand how the changes which are taking place within the organisation are impacting on staff and the services they provide.

Some of staff talked enthusiastically about the impact that new colleagues joining the service was having, bringing in fresh ideas and a desire for change, particularly in terms of organisational culture, which was influencing their peers. Others highlighted the improvements which had taken place in training provision and in the process for developing guidelines whilst at the same time, emphasising the importance of ensuring that communication about new practice remains accessible and effective.

Staff generally felt that sharing their ideas and experiences was helpful and the current staff engagement strategy is beginning to have an impact. Staff across all three sites and in community settings are being encouraged by managers to focus on how they could contribute to change and share their ideas for improvement. A number of staff members recognised the importance of not only identifying problems but using their ideas and skills to be part of the solution.

Condition for Sustainability – Culture Change

There is evidence of positive shifts in culture in key areas such as joint working between maternity and neonatal services, multidisciplinary working and addressing the blame culture.

Staff also talked about the impact on service users and there was a clear sense that women were now more involved in decision making and empowered to express their needs and wishes. However, it was recognised that COVID-19 restrictions had impacted on the ability of staff to connect with women and families.

This was particularly so in areas where staff wanted to spend more time supporting women's health and wellbeing in pregnancy and to enhance understanding about choices, including the use the Tirion Birthing Centre.

It was particularly encouraging to hear staff talk about projects they had initiated and to get a sense of their passion and commitment for improving and developing services, based on an understanding of how care impacts on the women and families using the service.

Although the Panel found an overriding sense of positivity, as is often the case in any organisational change programme on this scale, there is still further work to be done to take all members of staff on the improvement journey. It was evident that some staff are still unable or unwilling to articulate the obvious progress which has been made to date, instead focusing on the problems and challenges of the past and those they still face.

Perhaps understandably in the current environment, some staff focused on demand and capacity issues and the problems created by staff absence, often due to COVID-19 but also because staff had retired or moved to new roles. Some felt that this had an impact on the quality of the service they were able to provide, including the continuity of care that many women really appreciate.

It is important that all staff in the maternity and neonatal services have an opportunity to be part of the solution and staff should be regularly asked how they want things to change and how that objective can be achieved.

A structured engagement programme has been developed to ensure that there is a two-way flow of information between staff and managers to enable problems and issues which have the potential to impede the delivery of good quality services to be identified and addressed. This is in the early stages of implementation but provides a real opportunity to engage more staff in the change process moving forward.

The 'disconnect' felt by some staff has been recognised by the Health Board and it is actively seeking to change culture by adopting a bottom-up approach, building on the ideas and skills of staff and engaging with the entire workforce in develop their maternity and neonatal strategic vision.

Condition for Sustainability – Strategic Vision

Developed, agreed and communicated to the public; early actions delivered providing confidence that sustainable longer-term continuous improvement is achievable.

2.4 Stakeholder Engagement

During March and April 2022, the Panel consulted with key stakeholders with the aim of triangulating its assessment of progress against other external information and intelligence sources. This included conversations with regulatory and external review bodies such as Healthcare Inspectorate Wales (HIW) and Audit Wales (AW).

Following publication of the neonatal deep-dive report, conversations also took place with other regulatory bodies including the Nursing and Midwifery Council and the General Medical Council, as well as statutory bodies such as the Community Health Council. Additionally, the Panel consulted with Independent Members and staff-side representation from Cwm Taf Morgannwg University Health Board.

A broad theme which emerged from these discussions was the renewed uncertainty arising from the planned changes to the Health Board's operating model. The current Integrated Locality Group (ILG) operating model has been in place since April 2020, although maternity and neonatal services did not transition over to the new arrangements until the Spring of 2021.

The Health Board has recently undertaken a review of the effectiveness of this model and has agreed to restructure around acute and out of hospital service delivery rather than physical localities. This will result in the creation of overarching Care Groups with functional Clinical Service Groups feeding into the structure.

For maternity and neonatal services, a 'Women and Children's Care Group' will be established. Whilst this will undoubtedly create significant opportunities for better integration and enhance cross-site working, it will require careful management to ensure that the lines of accountability and governance, which are only just beginning to embed under the ILG model, are not disrupted.

Staff are only now starting to understand how the ILG structure works but the model will soon be changing. That is not intended to be a criticism. There is much to commend about revising the operating model. However, the transition will need to be carefully managed to ensure that momentum is not lost and staff remain engaged.

In their joint review of quality governance arrangements undertaken in November 2019, HIW and AW made 14 recommendations to support the Health Board in addressing issues such as:-

- improving the strategic focus on quality, patient safety and risk;
- strengthening leadership of quality and patient safety;
- improving organisational scrutiny and directorate level arrangements for quality and patient safety;
- improving the identification and management of risk;
- strengthening the management of incidents, concerns and complaints;
- improving the organisational culture and approach to organisational learning.

In May 2021, HIW and AW reviewed the position and found that the Health Board was making good progress in addressing these recommendations, particularly taking account of the challenges it has faced in responding to the COVID-19 pandemic. However, as there was still work to do in each of the improvement areas, all recommendations remained open.

The Panel has previously recognised that a number of these issues are cross-cutting with its work. The planned changes to the operating model will undoubtedly take time to embed throughout the organisation and this transition could impact on the progress made in addressing previous concerns about quality governance.

The Panel will continue to work with the Health Board and key stakeholders including HIW, AW and the Welsh Government to support a smooth transition of maternity and neonatal services into the new care group structure.

2.5 Current Assessment against IPAAF Maturity Matrices

When the Panel last reported in September 2021, it provided a brief overview of the way in which the Integrated Performance Assessment and Assurance Framework (IPAAF) had evolved over the preceding 12 months. Since then, further steps have been taken to align the maternity and neonatal assurance process with the organisation's targeted intervention self-assessment arrangements.

As a result, the maternity and neonatal IPAAF has now become an organisational level self-assessment process undertaken on a four monthly cycle. Each subsequent assessment compares progress against the previous assessment and against the agreed maturity matrix for each of the domains within the framework.

There is now a tiered approach to assessment within the Health Board. An initial assessment is undertaken by the Clinical Service Group (CSG) leads through a review meeting facilitated by the Improvement Director. This assessment is then reviewed and challenged by the Integrated Locality Group (ILG) Directors and designated Senior Responsible Officers (SRO) before being presented for further scrutiny by an Independent Member aligned to the special measures arrangements. The outcome of this challenge process is then discussed at a Board self-assessment session and if supported, ratified at the following Public Board.

In the Panel's view, this is a significant step forward which provides clear evidence of direct Board ownership of assessing the quality and safety of its maternity and neonatal services as part of its wider corporate development programme.

The approach which is being taken in the Health Board is increasingly being recognised as good practice and has been adopted by the Welsh Government in a number of other areas across NHS Wales where services require improvement.

The Panel considers that the IPAAF has now been embedded within the improvement programme and is owned by the service as a mechanism to reflect and evaluate learning. It promotes integration between services and allows progress to be reported to the Board via its committees in a structured format which Executives and Independent Members are now familiar with.

It also provides a structured and objective way to indicate to an external audience, the progress which the maternity and neonatal services are making over time.

Condition for Sustainability – IPAAF

IPAAF is being used effectively at service and Board level to regularly reflect upon and evaluate progress; maternity service assessed at 'maturity' level for safe and effective care with other domains progressing towards maturity; neonatal service assessed at 'results' level in all three domains; early evidence of progress against agreed key metrics.

During April 2022, the Health Board conducted its fifth self-assessment against the IPAAF maturity matrices. This is due to be presented to a public Board meeting for approval during May 2022. However, the conclusions are summarised below.

2.5.1 Maternity Services

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

- **Safe and Effective Care** is now in the ‘Maturity’ phase having progressed from ‘Results’ in the previous self-assessment. This position has been reinforced by a number of factors, including:-

  - development of the draft Maternity and Neonatal Assurance Framework;
  - high compliance with PROMPT training having been maintained;
  - establishment of digital handover boards;
  - roll-out of new CTG monitors and associated training.

- **Quality of Women’s Experience** is now firmly in the ‘Maturity’ phase with some elements approaching ‘Exemplar’ status. This position, an improvement on the previous self-assessment, has been reinforced by a number of factors, including:-

  - co-production of patient information and lobbying for the review of visiting restrictions through the My Maternity My Way Forum;
  - a reviewed and refreshed engagement plan;
  - virtual tours and the launch of the public website;
  - successful online engagement events including a session on infant feeding with over 2,800 online views.

- **Quality of Leadership and Management** remains in the 'Results' phase with a number of aspects approaching 'Maturity'. This position has been reinforced by a number of factors, including:-

  - partnership working with Trade Union colleagues;
  - successful management of the serious incident investigation backlog in collaboration with the NHS (Wales) Delivery Unit;
  - development of a Learning Needs Analysis framework;
  - staff engagement with Clinical Service Group (CSG) triumvirates.

These assessments are shown pictorially in Figure 1 below.

Figure 1: Maternity IPAAF Self-Assessment – April 2022

Domain	Basic	Early Progress	Results	Maturity	Exemplar
Safe and Effective Care				✓	
Quality of Women's Experience				✓	
Quality of Leadership and Management			✓		

2.5.2 Neonatal Services

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

- **Safe and Effective Care** is now firmly in the 'Early Progress' phase with a number of aspects of the service approaching 'Results'. This position, which remains unchanged from the previous self-assessment, has been reinforced by a number of factors, including:-

  - development of the draft Maternity and Neonatal Assurance Framework;
  - arrangements put in place for tertiary centre support with consultant visits to the tertiary unit and nurse rotations commencing in April 2022;
  - multidisciplinary simulation training established;
  - audit plan agreed across both sites for 2022/23.

- **Quality of Families' Experience** is now firmly in the 'Early Progress' phase. This position, which again remains unchanged, has been reinforced by a number of factors, including:-

  - secondment advertised for engagement lead post;

- joint debriefing established with paediatrics and maternity for families who have suffered a traumatic event;
- mechanisms in place for monitoring family concerns through bi-weekly governance meetings;
- low numbers of neonatal related concerns or complaints raised.

- **Quality of Leadership and Management** is now firmly in the 'Early Progress' with some aspects of the service approaching 'Results'. This is also a standstill position, reinforced by a number of factors, including:-

  - maintenance of BAPM compliance for nurse staffing levels;
  - improvements in data quality and dashboard development;
  - availability of psychological support for staff;
  - jump call policy in place and empowering staff.

These assessments are shown pictorially in Figure 2.

Figure 2: Neonatal IPAAF Self-Assessment – April 2022

Domain	Basic	Early Progress	Results	Maturity	Exemplar
Safe and Effective Care		✓			
Quality of Women's Experience		✓			
Quality of Leadership and Management		✓			

2.5.3 Panel Review

In discharging its oversight responsibilities, the Panel has reviewed the Health Board's conclusions based on evidence from a range of sources, including the outcomes of the recent assurance visit.

As part of this review, members of the Panel observed the CSG level self-assessment sessions and met with the SRO's to identify and discuss any divergence of opinion which emerged following their challenge sessions. The Chair of the Panel also observed the Board level self-assessment session.

Having done so, the Panel concluded that it was able to support the Health Board's self-assessment in full and concurred with the levels of maturity which had been agreed in each of the domains in both the maternity and neonatal frameworks.

2.5.4 What Does This Mean?

The shift from 'Results' to 'Maturity' in the Safe and Effective Care and the Quality of Women's Experience domains is a significant milestone for the Health Board in relation to its maternity services.

In simple terms, this indicates that the service is now broadly being delivered to the standards which are expected of a maternity service operating at this level within the UK health system. That does not mean that there is not more work to do; indeed, every service has ongoing development needs. However, it does indicate that the Health Board is now comparable to others in Wales in those specific domains and in some areas, particularly in respect of some aspects of its work in engaging with women and families, it may now actually be setting standards for others to follow.

It is important to note that the Quality of Leadership and Management domain remains in the 'Results' phase, largely because that is where much of the outstanding culture, leadership and strategy work sits.

The fact that the maturity assessment for the neonatal service remains at 'Early Progress' in all three domains is a reflection that the service is at a very different stage in its improvement journey compared to the maternity service. There has undoubtedly been some progress and in some aspects, the service is progressing towards 'Results'. However, the detailed improvement plans which are necessary to fully address the recommendations emerging from the deep-dive review are still being developed and as such, in the Panel's view, the overall assessment of 'Early Progress' is a reasonable reflection of the current position.

2.6 Joint Working between Maternity and Neonatal Services

Maternity and neonatal services are inextricably linked and should not be viewed in isolation; they provide a single pathway for the care of mothers and babies. It is essential that effective communication and coordination is applied across the services. This has been very clearly highlighted in the Panel's Thematic Neonatal Category Report which is being published alongside this progress report. For that reason, in addition to undertaking the maternity and neonatal self-assessments, the Health Board has also assessed its progress against improving joint working.

Whilst the Panel is not reporting this assessment separately because it is an integral part of the maternity and neonatal maturity matrices, there have been some key developments in terms of joint working which support the Panel's overall assessment of progress and are worthy of mention. For example:-

- the governance processes for maternity and neonatal services are now more integrated and regular cross-site meetings are taking place including Perinatal Mortality Review Tool (PMRT) and Avoiding Term Admissions Into Neonatal Units (ATAIN) meetings;
- there has been valuable input from maternity colleagues in the review of the neonatal escalation policy;

- although in its infancy, arrangements for transitional care are being developed and this has been established as a joint enterprise;
- there is increasing cross-site collaboration between the services which is resulting in much closer alignment of processes, policies and guidelines.

Despite this encouraging progress, the Health Board has recognised that more is needed to consolidate the progress made to date and has therefore identified some important next steps in further developing joint working. This includes:-

- strengthening consultant presence and establishing daily joint 'huddles' with consultant input;
- enhancing processes for sharing learning across services;
- ensuring that joint improvement activities can be readily shared in a variety of forums including regional and national quality improvement forums;
- recruitment to joint posts including a Quality Improvement Manager;
- financial investment in permanent posts to ensure sustainability.

The Panel is supportive of the next steps which the Health Board has set out for joint working in its milestone plan and believe that active medical engagement and medical leadership will be key elements in driving this work forward.

Condition for Sustainability – Medical Leadership

Medical leadership is visible and effective; there is leadership development support in place and the consultant body as a whole is actively engaged in driving forward service improvement.

2.7 Discharging the Royal Colleges' Recommendations

At the end of the last reporting period, the Panel confirmed that 55 of the 70 Royal Colleges' recommendations had been delivered whilst the remainder were work in progress at various stages of development. The Panel also signalled an intention to move away from the Royal Colleges' recommendations as the primary indicator of the Health Board's progress in improving its maternity and neonatal services.

The rationale for that was explained in some detail in the September 2021 Progress Report and as such, is not repeated here. However, in summary, given the current stage of the improvement journey and the Health Board's transition to a longer-term transformational approach, the Panel believes that the programme management framework offers a more meaningful way to evaluate progress, using the milestone plan and highlight reporting against milestones and key metrics as the gauge.

Over the last six months the improvement team has collated evidence against each of the remaining 15 recommendations and the 10 which required follow-up to ensure that actions had been embedded in practice. The Panel has systematically reviewed this evidence and agreed a position with the Health Board on each of the 'open' and 'follow-up' recommendations, the categorisations for which are detailed below.

Figure 3: Closure Categorisations for Royal Colleges' Recommendations

Categorisation	Definition
Close	All elements of the recommendation have been delivered and no further action is needed other than continuing to embed in practice.
Close with some outstanding elements	Substantial elements of the recommendation have been delivered but there are some ongoing issues yet to be fully addressed. These will be transferred across into the Health Board's milestone plan.
Close with all elements outstanding	Some aspects of the recommendation have been delivered but most elements remain to be delivered and these will be reflected in the Health Board's milestone plan (these include embedding cultural change, strategic planning and population health issues).
Administrative closure	The recommendation is no longer relevant given the passage of time or changes in circumstances or is duplicated by other recommendations.

The Health Board has initiated an internal process to agree the close categorisations for all remaining Royal Colleges' recommendations.

Further detail of the Panel's assessment against each 'open' recommendation (i.e. those which have not previously been verified) can be found at Appendix A. Additional information about each 'follow-up' recommendations (i.e. those which have been verified in the past but required monitoring and reassessment) can be found at Appendix B.

Those further developments effectively mean that at the end of this current reporting period, 62 (89%) of the Royal Colleges' 70 recommendations have been verified by the Panel as fully delivered, with the other eight (11%) remaining work in progress in various stages of completion.

Of the eight which remain work in progress, four have been substantially delivered and elements have been transitioned across into the milestone plan, whilst the other four are transformational change issues which will now be subsumed into the longer-term improvement programme.

Of the 10 'follow-up' recommendations, the Panel is satisfied that eight have been appropriately progressed and embedded in practice whilst two recommendations, although substantially delivered, have some elements which have needed to be transitioned into the milestone plan.

The Panel does not intend to report further on progress against the Royal Colleges' Recommendations and the Health Board is supportive of this approach.

It was hoped that as part of this report, the Panel would be in a position to make a formal recommendation to the Minister that the Royal Colleges' recommendations should be discharged. However, in order to do that, the Panel will need to be assured that all of the undelivered elements have been systematically transferred across into the milestone plan and the work programmes which sit behind it.

Unfortunately, due to enforced changes in personnel within the improvement team, there has been some slippage in this work being completed; as a result, the Panel is not currently in a position to make a formal recommendation that the Royal Colleges' recommendations be discharged.

The staffing issues have now been resolved and it is expected that the work will be completed within the next few weeks. However, the Panel wishes to be absolutely sure that everything which remains to be done has been systematically transferred across into the milestone plan and for that reason, the Panel has deferred making a formal recommendation until it next reports in September 2022.

Condition for Sustainability – Royal Colleges' Recommendations

The Royal Colleges' recommendations process is discharged; all recommendations are either verified as delivered by the Panel or scheduled for delivery within the Health Board's longer term Maternity and Neonatal Improvement Plan.

3 Neonatal Service Improvement

In March 2021, with the active support of the Health Board, the Panel made a recommendation to the then Minister for Health and Social Services 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 'deep-dive' review to assess the quality and safety of the neonatal services currently being provided at Prince Charles Hospital.

3.1 Neonatal Deep-Dive Review

The deep-dive review explored, in depth, all aspects of the hospital's neonatal service, including the way in which it is integrated with the maternity service, other Health Board services and the wider network of neonatal services across Wales.

Part way through the review, in August 2021, the review team identified a number of issues which were considered to have the potential to impact on the safety of the service. This included issues related to consultant cover, pharmacy support, joint working with the maternity service and standards of documentation. These issues were escalated to the Health Board and the Welsh Government for immediate action and in early September 2021, the Minister made a statement to the Senedd explaining what the Health Board was doing to respond to the concerns which had been raised.

The full deep-dive review was completed in November 2021 and a report setting out the Panel's findings was published by the Minister in February 2022; a copy of the report can be accessed here. The report concluded that the neonatal service at Prince Charles Hospital required significant improvement and made 42 recommendations, all of which were subsequently accepted by the Health Board.

During the course of their work, the review team did identify some strengths to build on, not least, dedicated and caring staff at all levels who are committed to the neonatal service and its ongoing development. This appetite for change was further evidenced during the Panel's assurance visit in February 2022, when the Panel's neonatal leads had their first opportunity to engage person to person with frontline clinical staff following the relaxation of COVID-19 restrictions.

The review team also recognised that a range of governance and assurance structures had been put in place which contributed to the safety and effectiveness of the service, albeit these were not yet functioning in the way they needed to. Additionally, it was acknowledged that the way in which serious incidents are identified, recorded and investigated was improving but further work needed to be done as part of the wider corporate response.

Although there were some strengths to build upon, a significant number of areas were identified, in addition to the safety-critical issues which emerged from the interim escalation, where the service needed to improve and in some areas, improve at pace. In particular, the Panel emphasised the need for the Health Board to:-

- progress at pace those of the issues escalated during August 2021 which remained outstanding and to ensure that the changes which had been put in place in response were embedded in practice;
- urgently assess, prioritise and integrate the actions required to address the remainder of 42 recommendations within their wider improvement plans;
- provide the same level of Board oversight and scrutiny to the neonatal service that it has to the maternity service, aided by a more comprehensive dashboard of relevant and accurate metrics.

A substantial number of the Panel's recommendations applied to specific aspects of clinical care or governance processes and it was emphasised that these should be addressed rapidly. To enable this the Panel advised that the Health Board should build on the learning from improvements which have and continue to be made in the maternity service, as well as other areas of the Health Board's improvement work.

It was acknowledged that other recommendations required cultural and behavioural change or investment in workforce and training which will take longer to action and embed in practice.

The Panel also considered that the findings and conclusions which emerged from the deep-dive review might offer wider learning for other health bodies in Wales and potentially beyond. Within the deep-dive report, the Panel therefore made four recommendations for consideration by the Welsh Government.

These were subsequently accepted and on 10 February, the Minister announced that the recently established Maternity and Neonatal Safety Support Programme will be the vehicle for taking forward these wider recommendations. A copy of the Minister's statement can be accessed here and background information on the MatNeo Safety Support Programme, as it has since become known, can be found in Section 6.2.

3.2 Assessment of Immediate Actions

In order to support the delivery of the deep-dive recommendations, an 'action plan template' was developed by the Panel and shared with the Health Board. This was designed to clarify the Panel's expectations and set out in more detail the work which needs to be done to address each of the recommendations, together with suggested timescales for completion to enable prioritisation.

The Panel identified five further recommendations which required immediate action (i.e. within three months) in addition to the 14 actions which the Health Board was expected to address in response to the immediate escalation in August 2021.

This is an ongoing process and at the time of writing, the Health Board has presented comprehensive packages of evidence against nine of the 19 areas for immediate improvement. The evidence provided has been evaluated by the Panel and the outcome for each is set out Appendix C, together with an assessment of the current position in relation to those actions or recommendations which in the Health Board's view remain 'work in progress'.

As a result of the Health Board's early response to the issues emerging from the neonatal deep-dive review, a number of safety-critical issues have been addressed and the key processes are now in place to enable continued improvement to be made. This includes, for example:-

- steps to improve prescribing standards and the development of a number of initiatives to change prescribing practice;
- improved daytime consultant cover which now runs from 08:30 - 16:30 with a number of consultants having protected time for neonatal work agreed within their job plans;
- a clear focus on improving documentation standards with plans in place to develop this further;
- evidence of more effective joint working between the neonatal and maternity teams, although there is still work to be done in this area (see Section 2.7).

The Panel acknowledges that there have been positive developments in all of the 19 areas identified as requiring immediate action, with preparatory work completed and some early results generated. However, the Panel has concluded that only five of the 19 areas for immediate improvement can be considered fully completed and embedded in practice at this time.

The Panel had hoped that by this time, they would have seen more evidence of tangible progress against the recommendations emerging from the deep-dive review and in particular those requiring more immediate action.

That said, the Panel acknowledges that there have been significant and sustained operational challenges within the neonatal service over the past six to eight months which have impacted on the capacity of the service to free up staff to engage in improvement activities. This is due in no small part to the continued impact of COVID-19 on staff sickness levels and some unavoidable long-term sickness in the senior management team; it is not a reflection of the commitment of the Health Board or the neonatal team to drive forward improvements in the service.

The Panel's concerns about the pace of progress have been raised and indeed are shared by the Health Board. They have been received constructively and there is a commitment to increase the pace of delivery in the coming months as additional capacity becomes available.

Condition for Sustainability – Early Neonatal Improvement

Recommendations within the Neonatal Deep Dive Report which require immediate action are verified as completed by the Panel and impacting positively on unit safety; a plan to deliver the remaining recommendations has been developed and agreed by the Panel.

3.3 Next Steps

It will be important for the Health Board to build on and transfer across the learning which has emerged from successfully taking forward maternity service improvements into the neonatal improvement process. If achieved, it will enable the programme to build momentum and deliver against the recommendations in a timely manner, focusing on the needs of babies, mothers and families using their services. In particular, there is much that can be learned from the progress which the maternity team has made in engaging with the women and families who use its services.

In tandem with addressing the immediate improvements, the Health Board needs to consider how the remaining deep-dive recommendations are incorporated within longer-term plans and the five-year vision. The involvement of women and families in this process and hearing the 'parent voice' remains of utmost importance.

The Panel and in particular the neonatal leads will continue to work alongside the Health Board's neonatal service to provide guidance and support and it is hoped that when the Panel next reports, there will be more significant developments to share.

Condition for Sustainability – Longer-term Neonatal Improvement

Longer term improvement plans are credible with a clear timeline and trajectory; there is evidence of meaningful progress against those elements of the improvement plan requiring short and medium term responses, in particular those recommendations linked to engagement with families.

4 Clinical Review Programme

The Panel's original terms of reference included a requirement to establish and undertake an independent multidisciplinary process to clinically review relevant episodes of care and to ensure that any learning which emerged from these reviews was acted upon by the Health Board and shared with other health organisations on an all-Wales basis as well organisations throughout the United Kingdom.

In response, the Panel developed a 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.

The Clinical Review Strategy set out the details of the programme which included three key elements:-

(i) a review of the maternity and neonatal care provided by the Health Board between January 2016 and October 2018 including 43 specific episodes of care identified as requiring further review by the Royal Colleges (referred to as the 2016-18 look-back);

(ii) a self-referral process, managed by the Health Board and overseen by the Panel to review matters referred directly by women and families in response to the Minister's commitment;

(iii) oversight of the Health Board's investigation of serious incidents which occurred post-October 2018 with a view to providing assurance that current systems and processes were fit for purpose.

In addition, in line with a recommendation made by the Royal Colleges, the Clinical Review Programme included a commitment to consider the need to extend the look-back exercise beyond 2016, possibly back to 2010. However, in consultation with the Welsh Government, it was agreed that this would be deferred until the outcomes of the 2016-18 cohort were known.

4.1 Overview of the 2016-2018 Look-Back

The Strategy sets out the inclusion criteria used to identify the episodes of care for review in the 2016-18 look-back and the methodology through which these would be explored. This methodology has evolved during the course of the reviews through process learning and the strategy has been periodically updated to reflect this.

In total, 161 episodes of care were identified for review in this phase of the programme. To enable delivery, clinical reviewers were recruited from November 2019 onwards and six multidisciplinary review teams established, supported by additional clinicians with responsibilities for quality assurance and drafting of individual feedback for women and families. The clinical reviews commenced in earnest during January 2020.

The primary purpose of the Clinical Review Programme is to identify organisational learning which will help to improve the quality and safety of maternity and neonatal services now and into the future and to provide answers, where answers exist, for women and families who have questions or concerns about the care they received.

In line with recognised practice, the Strategy identified three cohorts for review within the 2016-18 look-back as detailed below:

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 were stillborn
3. Neonatal mortality and morbidity	Babies who died following birth or needed specialist care

The Clinical Review Programme is not intended to apportion blame or to specifically seek out individual failings. However, where concerns have emerged relating to the professional competence or conduct of individual staff members, there are arrangements in place to enable such matters to be referred to the Health Board and as necessary to the appropriate professional bodies. To date, only a small number of individual referrals have been made to the Health Board and only one has been considered sufficiently serious to warrant a referral to the relevant professional body.

Further information about the escalation and referral process can be found within the Panel's Clinical Review Strategy.

4.2 Maternal and Stillbirth Categories

When the Panel last reported in September 2021, the first and second phase of the programme had concluded. The key themes and issues which emerged from the clinical review of the episodes of care in the maternal and stillbirth categories are similar in many respects. These can be summarised as follows:-

- a failure to recognise and respond to high-risk situations in a timely manner;
- inappropriate or inadequate treatment;
- failings in clinical leadership and oversight.

A number of women and families chose to share their experiences within the maternal and stillbirth categories. These stories were considered by the independent teams alongside clinical documentation as part of the review process and contained powerful narratives and insights about their experience of care.

Consistent themes were identified through the analysis of these stories which, from the women's and families' perspective, had an adverse impact on the overall quality of their care and contributed to the adverse outcomes they experienced.

The themes which emerged can be summarised as follows:-

- a lack of relevant and timely information to inform choices;
- a failure to understand and cater for women's individual needs;
- a failure to monitor and escalate their treatment when things changed;
- poor communication with and between those providing their care;
- bereavement support and care after birth.

Further information about the key themes and issues identified through the maternal and stillbirth clinical review categories, alongside the recommendations made by the Panel to support the Health Board in taking forward and implementing the necessary learning and improvements, can be found within the respective thematic reports published on the Welsh Government's website.

4.3 Neonatal Category

Since the Panel last reported the third and final phase, the process of reviewing the care of babies who sadly died or needed specialist care following birth, has now been completed. All women and families involved in this phase have been provided with an opportunity to receive their individual report of findings should they wish to.

Alongside this progress report, the Minister is publishing the Thematic Neonatal Category Report which summarises the key themes and issues to emerge from this cohort. This can be accessed here.

Whilst there have been new insights within the neonatal category, the Panel does not consider that anything fundamentally new has emerged beyond the key themes identified in the first two categories or in the clinical case assessments which were conducted as part of the neonatal deep-dive review.

This does not mean that the findings are any less relevant or indeed significant for those women and families involved. However, in terms of learning for the Health Board, the Panel does not believe it necessary to make any further recommendations beyond those already provided in the Thematic Stillbirth Category Report and Neonatal Deep-Dive Report.

4.4 Self-Referrals

In accordance with the Minister's commitment, the Health Board and the Panel jointly developed a pathway for reviewing episodes of care which had been self-referred by women and their families.

All of the self-referrals were triaged initially by the Health Board and either included within the Panel's Clinical Review Programme where they appropriately fitted the criteria or reviewed by the Health Board with oversight from the Panel's clinical leads. To date, 25 self-referrals have been received by the Health Board, all of which have now concluded and the findings have been communicated to families.

The self-referral process currently remains open for any women or families who have concerns about the maternity or neonatal care that they received within the Health Board regardless of the time period in which that care was provided. However, there have been no new self-referrals made since January 2021.

4.5 Post-October 2018 Serious Incidents

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 Panel's need 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 the recognition 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.

As set out in the Panel's last report, the Health Board's previous processes did not stand scrutiny and as a result, in May 2021, the NHS Wales Delivery Unit (NHSWDU) was commissioned by the Welsh Government to support the Health Board with this work.

The NHSWDU has undertaken a specific piece of assurance work within the Health Board's maternity and neonatal services both to strengthen their processes and systems for incident investigation and learning, as well as assisting in dealing with the backlog of serious incidents in a prioritised and timely manner.

In April 2022, the NHSWDU delivered its final report which in summary concluded that the Health Board had made significant progress in the management of serious incidents by the maternity and neonatal services.

However, there is still more work to be done to ensure that improvements are sustainable and all elements of previous recommendations are delivered in full. The Health Board will need to maintain focus to ensure that the progress which has been made is firmly embedded in practice and becomes 'business as usual'.

The ownership and support provided by the Health Board's corporate patient safety team has been a key factor in this achievement and the transferrable learning this has provided for other services within the Health Board is acknowledged. The Panel is confident that the maternity, neonatal and corporate quality and safety teams are fully aware of the improvements required and are currently working on their implementation which includes the updating of existing policies, guidelines and frameworks based on advice from the NHSWDU.

It is clear that more is needed in terms of the neonatal service contribution to investigations but this is already being picked up as part of the Health Board's ongoing response to the neonatal deep-dive recommendations. From the Panel's perspective, the report provided by the NHSWDU effectively 'closes off' this element of the Clinical Review Programme and the Panel is assured that the systems and processes for serious incident management and investigation are fit for purpose.

This is a significant milestone for the Health Board which represents the culmination of two year's work and its completion enables those serious incidents which have occurred since 01 October 2018 to be considered for closure as appropriate.

Condition for Sustainability – Serious Incident Investigation

NHS (Wales) Delivery Unit recommendations delivered and signed off; effective investigations being conducted on a 'business as usual' basis; all learning is routinely being identified and shared and there is evidence that this is driving improvements in care.

4.6 Pre-2016 Look-Back

As the final phase of the 2016-18 look-back has now concluded, the Panel feels it is timely for a decision to be made about the need for any further reviews beyond 2016.

The Panel has based its recommendation on the pre-2016 look-back on three broad conclusions which can be briefly summarised as follows:-

(i) the learning which has emerged from the Clinical Review Programme to date is broadly consistent with the findings and conclusions contained within the Royal Colleges' report. As such, it is unlikely that further organisational learning would be gained by extending the programme back beyond 2016;

(ii) although the potential for learning is in all probability limited, there are likely to be women and families who still have concerns and questions about the care they received prior to January 2016 and some form of recourse should remain available to enable those people to seek answers;

(iii) although the number of people who might come forward to ask for their care to be reviewed is difficult to determine, the level of interest from women and families in the current process (as indicated by the level of requests for detailed feedback from the current Clinical Review Programme and the number of referrals emerging from the current self-referral process) has been less than might have been anticipated.

Taking account of those conclusions, the Panel makes the following recommendation for consideration by the Minister for Health and Social Services:

Recommendation One – Pre-2016 Look-Back

The current Clinical Review Programme should cease when the current phase of activity concludes. The Panel's role in managing and overseeing the Clinical Review Programme should end at the same time and the Health Board should manage the process going forward with oversight from the Welsh Government.

The current self-referral process should transition to a Health Board-led process, based on the principles of the existing Putting Things Right (PTR) processes, which would provide recourse for those women and families still seeking answers about the care they received prior to 2016.

If this recommendation is accepted in principle by the Minister, more detailed proposals will then need to be developed in consultation with the Health Board, the Welsh Government and other key stakeholders including the Community Health Council or its successor body.

These arrangements will need to address a range of key issues, including but not limited to the arrangements for continued oversight of the process, externality within the reviews where this is appropriate, which inclusion criteria should be adopted and how the arrangements will be resourced.

Careful consideration will also need to be given to how the arrangements are communicated to ensure that those who may wish for their care to be reviewed are aware of the arrangements and how to make a request. In that regard, there is much learning that can be transferred from the way in which the original self-referral pathway was communicated.

It should be noted that PTR regulations are currently limited to care provided within 12 months unless there are exceptional circumstances. Increasing the scope to recognise these as exceptional circumstances would allow the principles of PTR to be applied for those women and families who received care more than 12 months ago, covering the period beyond 2016 and avoiding the need to establish additional mechanisms specifically for this purpose.

It is anticipated that when the Panel next reports in September 2022, it will be able to set out in detail how those women and families who wish to, can continue to put themselves forward for consideration of a clinical review into the care they received prior to 2016.

4.7 Closure of Clinical Review Programme

The Health Board has a robust process in place for tracking and monitoring individual actions which have been identified through the Clinical Review Programme. The Panel oversees this process as part of its wider oversight role. Where appropriate, any significant actions are incorporated into the Maternity and Neonatal Improvement Plan.

Collaborative work is currently underway between the Panel and the Health Board to develop a process for closing down the various strands of the Clinical Review Programme. Given the progress which has been made to date in taking forward the identified learning from the reviews, it is anticipated that the Health Board will take increasing ownership of the closing stages of the process.

This will provide an opportunity to demonstrate its growing maturity in taking forward and embedding improvement actions, utilising the internal assurance mechanisms which have been established more broadly within the improvement programme from which the Panel can derive its own assurance.

It remains vital that the outputs from the clinical review process, in particular the individual review findings and feedback for women and families, are securely stored and available should any of these families decide that they wish to receive them in the future. These records will be maintained and stored within the Health Board's 'Safe Haven' database established specifically for the clinical review process to enable this.

Condition for Sustainability – Clinical Review Programme

Clinical Review Programme is fully completed; emerging recommendations and Health Board actions have been fully addressed.

The Panel is working with the Chief Nursing Officer's team to develop plans for a national maternity and neonatal summit which it is anticipated will be held in the Summer of 2022. It is intended that this will bring together the significant amount of learning which has emerged from the Panel's Clinical Review Programme as well as other key reports and national audits.

At this time it is anticipated that the interim findings will also be available from the initial discovery phase of the Maternity and Neonatal Safety Support Programme and this information will be evaluated and discussed to identify key actions for Wales. Further background information on this programme can be found at Section 6.2.

5 Engagement with Women and Families

When the Panel last reported in September 2021, it noted that a fundamental shift had been observed in the Health Board's overall approach to engaging with women and families which had resulted in increased confidence amongst those using the service. There was a clear and genuine belief in the value of engagement and the infrastructure was in place to make that shift sustainable in the longer term.

Although COVID-19 continued to impact on the way in which the Health Board has been able to engage with its communities, the Panel recognised the creative use of social media and other forms of remote technology deployed to engage and build co-production with women and families using the maternity service. These new approaches have been successful in reaching out to many more local people than would have been involved previously.

5.1 Developments in Engagement and Communication

The comprehensive approach to engagement with women and families by the maternity service has been further developed and presentations from the Consultant Midwife (who is also the Quality of Women's Experience Workstream Lead) are impressive in demonstrating the increased strength, reach and innovation of engagement.

In particular, the role of the My Maternity My Way Forum has demonstrated effective co-production and highlights the way in which involvement has been knitted into the work and planning of the Health Board at all levels. Women's stories about their experience of maternity care are heard regularly throughout the Health Board in its meetings and as part of staff training, thereby impacting on culture and furthering an understanding of their needs, especially around communication.

Several members of My Maternity My Way have participated in stakeholder panels and interviews to support the recruitment of key members of the maternity team including the Clinical Director, Women's Experience Midwife and the Director of Midwifery.

Women's and families' needs and experiences have been core to the co-production of information. My Maternity My Way members have supported the development of a series of leaflets including Homebirth, Induction of Labour, Latent Phase of Labour and information about Tirion Birthing Centre.

Their involvement has been at its most valuable in co-producing 'Memory boxes' to support bonding and memories for some of most vulnerable women and families where a baby is cared for in foster care. The issues identified from wider engagement with women and families are now informing the sub-groups of My Maternity My Way with Birth Partner and Infant Feeding Groups now meeting to ensure that the needs and wishes of women and families influence service delivery and ongoing improvement.

Women and families who have continuing questions after the birth of their baby have been able to discuss their experience further through the Afterthoughts service. The Panel heard during its assurance visit how this debrief service is now even more accessible across the geographical area of the hospital sites with increased availability of appointments to share experiences and to ensure that women and families have the support and answers they need. Debrief sessions are held with input from maternity, neonatal and paediatric services so that women and families have a coordinated response which addresses their questions across their pregnancy, birth and postnatal journey.

The Panel identified in its previous report that the implementation of PREMs (Patient Reported Experience Measures) would ensure systematic collection and assessment of 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. The surveys were built in co-production with women and families who use the service and since Autumn 2021, data capture for the system has been live.

PREMs is hosted by CIVICA and the system in the Health Board is a pilot for all health boards across Wales. As a result, in addition to data being continuously generated and analysed to provide an in-depth picture of women's experiences, the system is being further developed and assessed with any design and delivery problems ironed out in real time. For example, feedback from women has identified that some questions need to be clarified to improve understanding and the quality of responses.

The refining of the system, including ensuring that accurate contact information is available to encourage survey take-up, will benefit the feedback and identification of themes for the Health Board and, ultimately, the design and delivery of the system across Wales.

Analysis of feedback has resulted in early reports of the main themes for the Health Board which include information needs, feedback on improvements for the postnatal environment and, inevitably, negative feedback on the COVID-19 related restrictions on partners' attendance in maternity settings. Work continues to produce meaningful reports, including a month by month heat map of key issues.

5.2 Next Steps in the Engagement Journey

In the Panel's last report, it was recognised that some of the limitations on the range of engagement as a result of COVID-19 restrictions had resulted in delays to the full roll-out of the Health Board's engagement strategy. It was important that momentum was maintained to ensure that improvement and service design was informed by and delivered real benefits for women, their babies and their families using the service.

Therefore, the Panel is assured that the Health Board has not only regained momentum over the last six months but has built a stronger and wider base for engagement with women and families using maternity services, with an enhanced strategy that has been acknowledged as leading and innovative across Wales.

It is important that there is continuing evidence that the products of that engagement are influencing the improvement in maternity care, organisational culture and staff communication.

However, the Panel's 'listening to families' engagement exercise which was conducted as part of the neonatal deep-dive and explored experiences of neonatal care at Prince Charles Hospital identified significant opportunities for improvement in the way in which women and families are engaged in their care, as well as how they can contribute to the design and development of the service.

Building engagement opportunities for women and families throughout their pregnancy, birth and postnatal care, as well as within their experience of neonatal care, is a key priority for the Health Board over the next six months.

The Panel is aware that this year, My Maternity My Way will work with the neonatal service to develop an engagement group for parents and babies who have used the Health Board's neonatal service. A Bereavement Group will also be developed to create opportunities for those who sadly have experienced pregnancy loss and bereavement to provide feedback and identify opportunities for improvements.

The actions which would demonstrate that the Health Board has a sustainable engagement strategy which consistently delivers opportunities for engagement across maternity and neonatal services are:-

(i) the refreshed engagement strategy should be further rolled out so that engagement and communication methods which build on networks and local contacts reach into all communities, especially those which may have the greatest needs, provide a source of regular feedback of women's and families' experiences;

(ii) mechanisms for the collection and analysis of PREMs feedback are fully in place and key themes and issues are routinely reported in a meaningful way and addressed systematically;

(iii) routine reporting at a senior level in the Health Board of evidence of change and improvement as a direct result of engagement in maternity and neonatal services, alongside regular feedback to patients, the public and local communities who have been involved, through the website, social media and other accessible methods;

(iv) the neonatal service placing even greater focus on the strategy, design and delivery of engagement with families, including making contact and building relationships with recent and past users of the service and importantly, demonstrating that it has learned from the approach 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 into the milestone plan. The Panel will continue to monitor developments to make sure that the actions result in tangible outcomes for women and families using the service.

Condition for Sustainability – Maternity Engagement Strategy

Strategy being delivered to plan and timescale; PREMs process embedded; evidence that outputs of PREMs and data from other engagement sources is being systematically evaluated and driving tangible service improvement.

5.3 Complaints and Concerns

In its last report the Panel recognised that, although there had been more timely responses to complaints and concerns, there appeared to have been some regression linked to the transition to the ILG structures. Work was ongoing to develop stronger links back to the service to ensure valuable learning was not lost. The Panel and the Health Board acknowledged that this was something which would need to be monitored going forward.

Over recent months, discussions during the Panel's assurance visit, findings from internal audits as well as feedback from independent sources have highlighted continuing issues around delays in response to complaints and concerns, the quality of responses, inequity of responses across sites and insufficient demonstration of systematic learning from findings.

The Health Board has acknowledged these problems and is conducting further work, including a second audit and increasing resources and focus at hospital site level to improve the quality, equity and timeliness of responses, in addition to ensuring that there is a robust process and framework to demonstrate learning from investigations and outcomes. The Panel will continue to monitor the progress of the actions outlined.

6 Next Steps and Recommendations

Over the last six months, the Health Board has continued to make further incremental progress in relation to its maternity service and the programme management arrangements which have been put in place to support the wider improvement process have been further strengthened.

It is clearly evident that the maternity and neonatal services' improvement journeys are at different stages. However, there have been positive developments in all of the 19 areas identified by the neonatal deep-dive review as requiring immediate action, with preparatory work completed and some early results generated.

It is important that momentum is now maintained within the neonatal improvement programme and the Panel welcomes the commitment from the Health Board to increase the pace of delivery in the coming months.

6.1 Achieving Sustainable Improvement

It will be seen from the analysis contained within this report that the Health Board is incrementally moving beyond its initial focus on strengthening its systems and processes towards a longer-term transformational change programme which will, if successfully delivered, ensure that both maternity and neonatal services are not only safe and fit for purpose but are also sustainable in the longer term.

The Board is also taking increasing ownership of the Maternity and Neonatal Improvement Programme and ensuring that it is integrated into day-to-day service delivery and into the organisation's wider strategic development plans.

In consultation with the Welsh Government and the Health Board, the Panel has identified and agreed a set of conditions which it believes would provide a reasonable degree of assurance that the Health Board's improvement journey is sustainable. These conditions, which the Panel is referring to as 'conditions for sustainability', have been emphasised throughout this report in purple boxes aligned to the areas of work they relate to. They are also outlined in Appendix E.

In developing the conditions for sustainability the Panel was anxious to avoid creating another set of objectives which would divert the Health Board's attention away from what needs to be done to improve services. On that basis, the conditions focus on those things which should be in place within the next six to nine months as a direct result of the Health Board delivering against the road map, milestone plan and longer-term vision and strategy which it has and continues to develop.

The Panel has tried to make the conditions as objectively based as possible but where there is an element of subjectivity, this has been linked to existing assessment processes which are already in place as part of the current working arrangements.

The Panel has also tried to make the conditions as specific as possible so that there is a clear and shared understanding of what is expected and over the next few weeks, will be working with the Health Board to define the evidence required to demonstrate that each of the conditions has been achieved.

The Panel believes that if the situation evolves as anticipated over the next six months, the Panel should be in a position when it next reports in September 2022 to provide the Minister with an assessment of whether it believes that the Health Board's improvement journey is sustainable. That will then enable the Minister, should she so wish, to consider what is necessary in terms of continued external oversight going forward.

6.2 Maternity and Neonatal Safety Support Programme

On 24 January 2022, the Minister for Health and Social Services announced a significant investment by the Welsh Government to improve the quality of maternity and neonatal care across Wales. The Minister also announced the development of a Maternity and Neonatal Safety Support Programme led by the Chief Nursing Officer (CNO) and the Deputy Chief Medical Officer. A copy of the Minster's statement can be accessed here.

It is anticipated that this programme will enable a clear and consistent approach to maternity and neonatal service safety across Wales. It is being developed, in part, based on the learning from Cwm Taf Morgannwg, building on the Health Board's recently published Quality and Safety Framework. The programme is intended to identify at local and national levels the frameworks, pathways and metrics which need to be developed to enable this.

Within the first phase of the programme, Improvement Cymru has been commissioned to work alongside health organisations in Wales, providing expertise and developing an independent assessment of the national framework for oversight of maternity and neonatal services to identify key priorities for improvements. The Panel will be working closely with Improvement Cymru to ensure that the learning from its Clinical Review Programme and wider work informs the initial discovery phase of programme.

In support of that, it is anticipated that a national maternity and neonatal summit will be hosted by the CNO during the Summer of 2022. This will bring together the learning which has emerged from the Panel's work as well as other key reports and national audits to explore how similar issues to those which emerged in the former Cwm Taf University Health Board can be avoided in future.

The summit will inform the next steps for the Maternity and Neonatal Safety Support Programme, ensuring that the learning which has emerged from the Panel's work with the Health Board contributes to the provision of safe, effective, high quality care for mothers, babies and their families across Wales.

6.3 Recommendation

The Panel would invite the Minister to consider one recommendation arising from this report which relates to the next steps in the Clinical Review Programme and specifically, to consider whether there is a need for a further look-back exercise beyond 2016. Further information can be found in Section 4.6 of the report.

Recommendation One – Pre-2016 Look-Back

The current Clinical Review Programme should cease when the current phase of activity concludes. The Panel's role in managing and overseeing the Clinical Review Programme should end at the same time and the Health Board should manage the process going forward with oversight from the Welsh Government.

The current self-referral process should transition to a Health Board-led process, based on the principles of the existing Putting Things Right (PTR) processes, which would provide recourse for those women and families still seeking answers about the care they received prior to 2016.

7 Appendix A – Schedule of 'Open' Royal Colleges' Recommendations

	Recommendation Description	Agreed Status
7.1	Urgently review systems in place for: • data collection, • clinical validation, • checking the accuracy of data used to monitor clinical practice and outcomes, • and what information is supplied to national audits.	**Closed:** Evidence provided meets recommendation requirements.
7.7	Ensure an environment of privacy and dignity for women undergoing abortion or miscarriage in line with agreed national standards of care.	**Closed with all elements outstanding:** Evidence provided did not recommendation requirements. Plans for the Gynaecology Assessment Unit need to be reviewed in detail and key dates for completion need to be added to the improvement plan.
7.8	Ensure external expert facilitation to allow a full review of working practice to ensure: • patient safety is considered at all stages of service delivery, • a full review of roles and responsibilities within the obstetric team, • the development and implementation of guidelines, • an appropriately trained and supported system for clinical leadership, • a long term plan and strategy for the service, • there is a programme of cultural development to allow true multi-disciplinary working.	**Administrative Closure:** Evidence previously provided meets the requirement for some elements of this recommendation. However, the remaining aspects overlap with the strategy development work (**7.67**) and duplicated.
7.17	Ensure training is provided for all SAS staff to ensure that they are: • up to date with clinical competencies, • skilled in covering high risk antenatal clinics and out-patient sessions.	**Closed:** Evidence provided meets recommendation requirements.

	Recommendation Description	Agreed Status
7.19	Ensure that a system for the identification, grading and investigation of SIs is embedded in practice, through: • appropriate training to key staff members, • making investigations multidisciplinary and including external assessors.	**Closed:** The Panel note external neonatology input into serious incident investigations is still in its infancy however this will be picked up in response to the neonatal deep-dive escalation action 7 (see Appendix C for further detail).
7.20	Actively seek to remove the 'blame culture' to allow all staff to develop a willingness to report and learn from SIs.	**Closed:** Evidence provided meets recommendation requirements.
7.31	Ensure a robust plan of births anticipated in each midwifery led unit and consultant led unit is undertaken, • ensure involvement of paediatric staff for all future service design reviews and actions.	**Closed with some outstanding elements:** Strategy development needs to include long term demographic planning and demand modelling for future births. This should be jointly completed by the maternity and neonatal services based on agreed strategic service change principles.
7.35	Undertake a training needs assessment for all staff to identify skills gaps and target additional training.	**Closed with some outstanding elements:** Improvement programme plans need to demonstrate achievement of statutory training compliance and the completion of a Learning Needs Analysis which builds on the Training Needs Analysis already in place for maternity services.
7.44	Support training in clinical leadership, • the Health Board must allow adequate time and support for clinical leadership to function.	**Closed with some outstanding elements:** Improvement programme plans need to include agreed Leadership Development Plan activities.

	Recommendation Description	Agreed Status
7.45	Provide mentorship and support to the Clinical Director • define the responsibilities of this role, • ensure there are measurable performance indicators, • ensure informed HR advice to consistently manage colleagues' absence and deployment of staff to cover the needs of the service, • consider buddying with a Clinical Director from a neighbouring Health Board.	**Closed:** Evidence provided meets recommendation requirements.
7.51	Ensure responses to complaints and concerns is core to the work being undertaken to improve governance and patient safety: • Review and enhance staff training on the value of listening to women and families, • Review the process of investigation of concerns, compiling responses, handling 'on the spot' issues and ensure that all responses and discussions are informed by comprehensive investigations and accurate notes, • Prioritise the key issues that women and families have highlighted to improve the response, • Ensure that promises of sharing notes and providing reports to families are delivered, • Clarify the process regarding the triangulation of the range of information sources on patient experience, SIs, complaints and concerns and other data and ensure that there is a rigorous approach to make sense of patterns of safety and quality issues, • Review the learning from the SIs in relation to misdiagnosis, failure to seek a second opinion and inappropriate patient discharge.	**Closed with all elements outstanding:** Improvement programme plans need to include embedding of complaints, concerns and clinical incidents into service governance, with regular reporting, service improvements resulting from the data, and periodic thematic reports.
7.56	Provide training for staff in communications skills, in particular on: • Empathy, compassion and kindness.	**Closed with all elements outstanding:** Improvement programme plans need to include Culture Development Plan activities.

	Recommendation Description	Agreed Status
7.63	Independent Board members must challenge the quality of the data which informs the reports which they receive and rely upon for assurance.	**Closed with some outstanding elements:** Development of a Maternity Service Dashboard and a data driven reporting culture is required to enable Members to make independent judgements. This needs to be encompassed in the longer term improvement programme plans.
7.67	Develop a strategic vision for the maternity service and use the current opportunity of change to create a modern service which is responsive to the women and their families and the staff who provide care.	**Closed with all elements outstanding:** Improvement programme plans need to include plans to develop a strategy for Maternity and Neonatal services within the context of the wider CTM2030 strategy.
7.70	Ensure that any future service change for the development process of the maternity service as a whole is inclusive for all staff and service users. •Ensure the service is adequately staffed to ensure that all staff groups are able to participate in developing the vision •Consider an externally facilitated and supported process for review. •Consider seeking continued support from HIW and the Royal Colleges to undertake a diagnostic review of the service particularly in relation to changes in service provisions.	**Administrative closure:** Due to a significant overlap, this recommendation has been merged with **7.67**.

8 Appendix B – Schedule of 'Follow-Up' Royal Colleges' Recommendations

	Recommendation Description	Agreed Status
7.5	Agree a CTG training programme that includes a competency assessment which is delivered to all staff involved in the care of pregnant women, both in the antenatal period and intrapartum.	**Closed:** Evidence provided meets recommendation requirements. Training compliance will be demonstrated in the outstanding element of **7.35**.
7.18	Agree cohesive methods of consultant working after the merger with input from anaesthetic and paediatric colleagues.	**Closed:** Evidence provided meets recommendation requirements.
7.22	Actively discuss the outcomes of SIs in which individual consultants were involved in their appraisal.	**Closed:** Evidence provided meets recommendation requirements.
7.23	Improve learning from incidents by sharing the outcomes from SIs on a regular basis and in an appropriate, regular and accessible format.	**Closed:** Evidence provided meets recommendation requirements.
7.27	Consider extra resource to the Maternity Governance and Risk team to ensure: • workload is manageable, • that Datix are reviewed, graded and actioned in an appropriate and timely manner.	**Closed with some outstanding elements:** Improvement programme plans need to include a review of resourcing in six months' time.

	Recommendation Description	Agreed Status
7.30	Ensure the Medical Director has effective oversight and management of the consultant body by: • making sure they are available and responsive to the needs of the service, • urgently reviewing and agreeing job plans to ensure the service needs are met, • clarifying what is to be covered as part of SPA activity (audit, governance, teaching, guidelines, data assurance, train more consultant obstetricians as appraisers), • ensuring the most unwell women are seen initially by a consultant and all women are seen by a consultant within 12 hour NCEPOD recommendation (national standard).	**Closed with some outstanding elements:** Improvement programme plans need to include an audit in six months' time to assess the average and range of time taken for emergency admissions to be reviewed at consultant level.
7.32	Ensure obstetric consultant cover is achieved in all clinical areas when required by: • reviewing the clinical timetables to ensure that 12 hour cover per day on labour ward is achieved, • undertake a series of visits to units where extended consultant labour ward presence has been implemented. • considering working in teams to ensure a senior member of the team is available in clinics and provide cross cover for each other, • considering the creative use of consultant time in regular hours and out of hours to limit the use of locums.	**Closed:** Evidence provided meets recommendation requirements.
7.36	Clinical supervision and consultant oversight of practical procedures must be in place for all staff including specialist midwives and staff doctors.	**Closed:** Evidence provided meets recommendation requirements.

	Recommendation Description	Agreed Status
7.37	Develop an effective department wide multi-disciplinary teaching programme. • this must be adequately resourced and time allocated for attendance by all staff groups including specialist clinical midwives and SAS doctors. • attendance must be monitored and reviewed at appraisal.	**Closed:** Evidence provided meets recommendation requirements.
7.40	Review the skills and competencies of the senior clinical midwives covering for tier 1 doctors to ensure: • their scope of practice is clearly defined, • the Health Board and the individuals are protected against litigation risk for their extended roles.	**Administrative closure:** The identified roles no longer exist.

9 Appendix C – Progress against Neonatal Deep-Dive Immediate Actions

	Improvement Needed	Agreed Minimal Intervention	Position
ESC. 1	The Health Board must introduce immediate make safes to support safe prescribing in practice.	• Good prescribing guide available and displayed for all staff groups to utilise. • Staff training for all staff on prescribing • Staff refuse prescriptions that don't follow the good prescribing guide. • Nursing crib sheet in bullet point form for checking steps for safe medicine administration.	**Complete**
ESC. 2	The Health Board must continue to show an improvement in the working relationship with maternity services in numerous areas.	• In-utero pathway to ensure clear plan for assessment and transfer of women with pregnancy at risk of requiring neonatal intensive care specifically those outside of the scope of practice for the Health Board's neonatal service. • Clear processes to capture when change of outcome where intrauterine transfer is not possible including evidence of rigorous review of factors associated with maternity decision making and management. • Standardised ongoing audit and feedback mechanism to clinical teams, Board and network regarding cases.	**Work in Progress**
ESC. 3	The Health Board must ensure consultant cover for the neonatal service is safe and effective.	• Consultants providing neonatal care should undertake a minimum of 4 service weeks per year to provide greater consistency to the neonatal team and babies experiencing care. • Identification of a core group of consultants sharing responsibility for, overseeing the work and standards of the wider consultant group, and leading the service • Consultant cover on the neonatal unit should be immediately extended to 8.30am to 4.30pm Monday to Friday. • Consultants with neonatal interest must have protected time to ensure the neonatal service is covered by senior medical staff with an understanding of the expertise required to support a safe neonatal service and to acknowledge when escalation to NICU services is required for either advice or transfer.	**Complete**

	Improvement Needed	Agreed Minimal Intervention	Position
ESC. 4	The Health Board must ensure immediate improvements are implemented to support expert clinical decision making for the sickest and most vulnerable patients in the service.	• The referral threshold for advice from a nominated NICU should be clearly articulated for all clinical staff and should be at a level where any baby with complex needs or requiring ICU treatment are discussed at the earliest opportunity for colleagues to ensure clinical decision making is supported by expert clinicians immediately. • A clear process should be in place to ensure continued early uplift for all infants requiring ongoing ICU treatment to ensure timely transfer.	**Work in Progress**
ESC. 5	The Health Board must review its cooling practice in line with national frameworks and ensure local practice meets this standard.	• All staff must have in date equipment competency for all equipment utilised within cooling treatment. • Standards of documentation around decision making for cooling should include as a minimum: criteria met and how, full detailed neurological examination and full details of a conversation with NICU/CHANTS. • Continued use of Wales Maternity and Neonatal Network pathway to supplement cooling specific medical and nursing documentation to support the instigation of safe cooling practice. • All cases where an infant received cooling treatment must have a standardised detailed MDT review alongside maternity.	**Work in Progress**
ESC. 6	The Health Board should immediately review all cases of unplanned extubation occurring in the service.	• Gain understanding of rates of unplanned extubations per 1000 ventilator days compared to nationally described incidence. • Local Improvement work around this issue should be collaborative with a local NICU to understand practices and safeguards already available to be adapted for the service in the Health Board. • Datix/audit for all unplanned extubations. • Changes in securing practice to prevent extubations (**Note:** since escalation no unplanned extubations have been reported).	**Work in Progress**

	Improvement Needed	Agreed Minimal Intervention	Position
ESC. 7	The Health Board must ensure clinical incident reviews, SI reviews and PMRT/Mortality reviews are carried out as an MDT with external support from colleagues within the local NICU to provide clinical expertise and questioning.	• Establish and monitor SI processes seeking additional clinical expertise when required to support local learning regarding what a good review looks like. • Wider Health Board engagement in governance reviews from corporate patient safety team. • Ensure timely feedback to staff reporting incidents and also of lessons learnt to avoid repeated incidents of harm. • Agreed changes in practice must be described in context to ensure staff understand the rationale and expected outcome of changes. • Neonatal Datix Trigger list to be updated to include: transfers out, infants born <32/40, term admissions, unplanned extubations. • Communication to staff highlighting trigger list changes and why these have been added.	**Work in Progress**
ESC. 8	The Health Board continue to progress a robust mechanism for reviewing all term admissions to the neonatal unit alongside obstetric and maternity colleagues.	• Themes and learning from Term Admission reviews must be disseminated to the wider teams and immediate interventions identified to reduce unnecessary term admissions should be implemented. • Support and advice from the local NICU service where this process is well established on how term admissions can be reduced • Datix to continue to be completed for every term admission.	**Work in Progress**

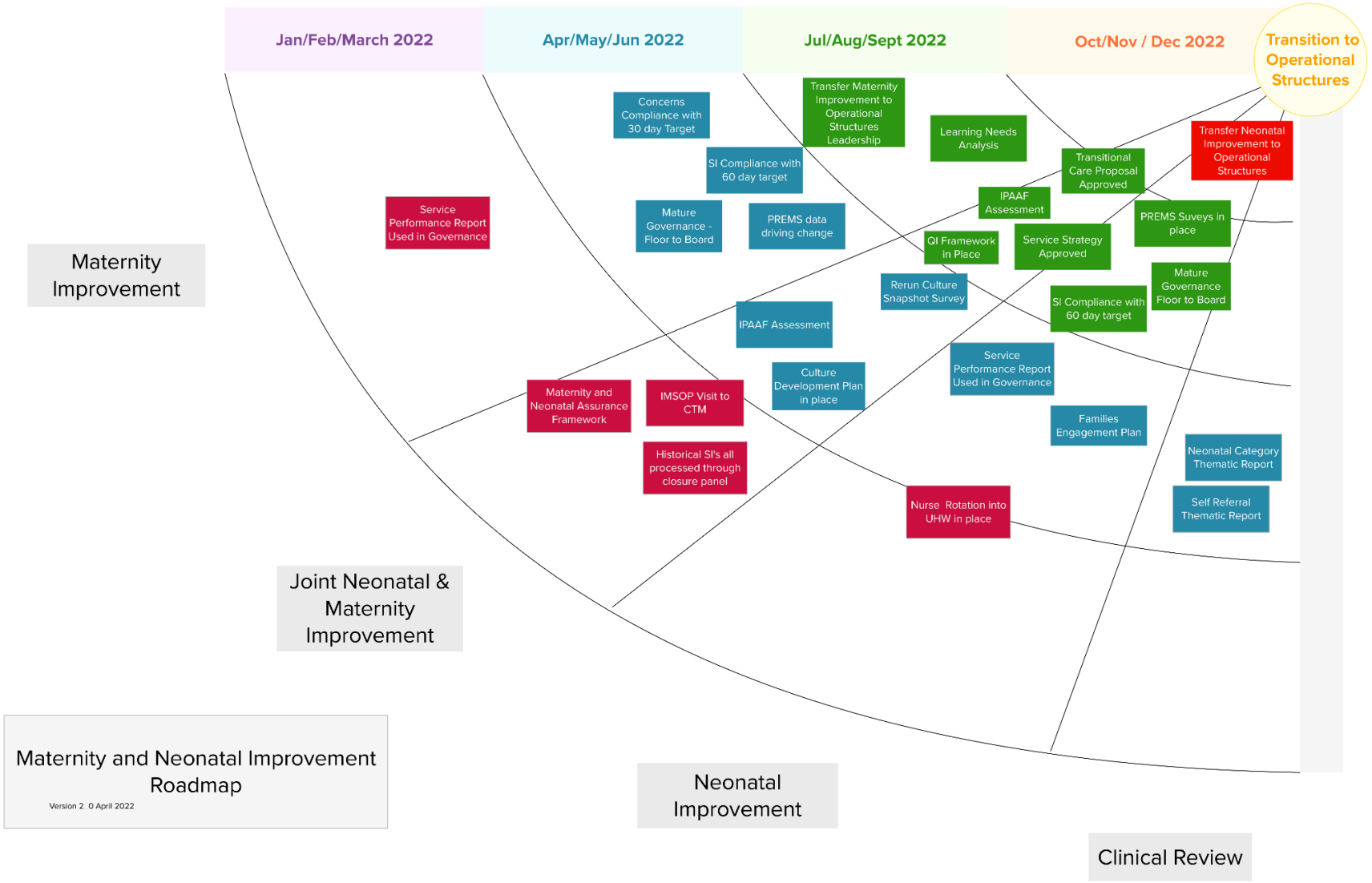
	Improvement Needed	Agreed Minimal Intervention	Position
ESC. 9	The Health Board should review current formal radiology reporting mechanisms and request an external review by a paediatric radiologist with neonatal experience to highlight areas of concern.	• Seek support from a paediatric radiologist from a tertiary centre to audit recent formal radiology reporting. • Ensure all radiology imaging is reviewed and interpretation documented by a consultant within the neonatal service.	**Work in Progress**
ESC. 10	The Health Board must undertake and immediate documentation review and introduce supportive documents to assist in improving documentation standards.	• Communication and education/training for all staff regarding standards of documentation as per governing bodies. • Introduce supportive documents: o Procedure chart with priority for intubation; central access and chest drains; o Chart for recording communication with NICU for advice; o Chart for recording referral to CHANTS for transfer; o Scribe sheet for managing resuscitation on the NNU and on Delivery Suite.	**Work in Progress**
ESC. 11	The Health Board should consider actions to support working with families to understand the impact of the listening exercise and improving family involvement in the service.	• Engage parents with experience of PCH Neonatal service and establish mechanisms to capture family experience feedback during and after when their babies are cared for on the unit. • Review and organise family feedback into themes and a useable review format.	**Work in Progress**

	Improvement Needed	Agreed Minimal Intervention	Position
ESC. 12	The Health Board must improve the staff culture on the unit to ensure all staff feel valued and listened to.	• MDT Team (including improvement team) building focused on joint working, • MDT SIMS to continue with evidence of participation from the full maternity and neonatal team. • Staff engagement exercise undertaken • Undertake a Safety Culture survey to allow demonstration of change/improvement.	**Work in Progress**
ESC. 13	The Health Board improvement hub and clinical teams must work together to understand the common goal of a safer service.	• Improvement team must work to engage the clinical team with the journey of improvement. • The clinical team must be supported to take ownership of the service and understand their role within improvements.	**Work in Progress**
ESC. 14	The Health Board must introduce a clear audit structure to monitor improvement and evidence the effectiveness of the service.	• Have a clinically led audit system that identifies, prioritises, plans, undertakes, monitors, and reviews audit outputs across the service. • Review and advice of Audit System by local NICU (or another LNU).	**Work in Progress**

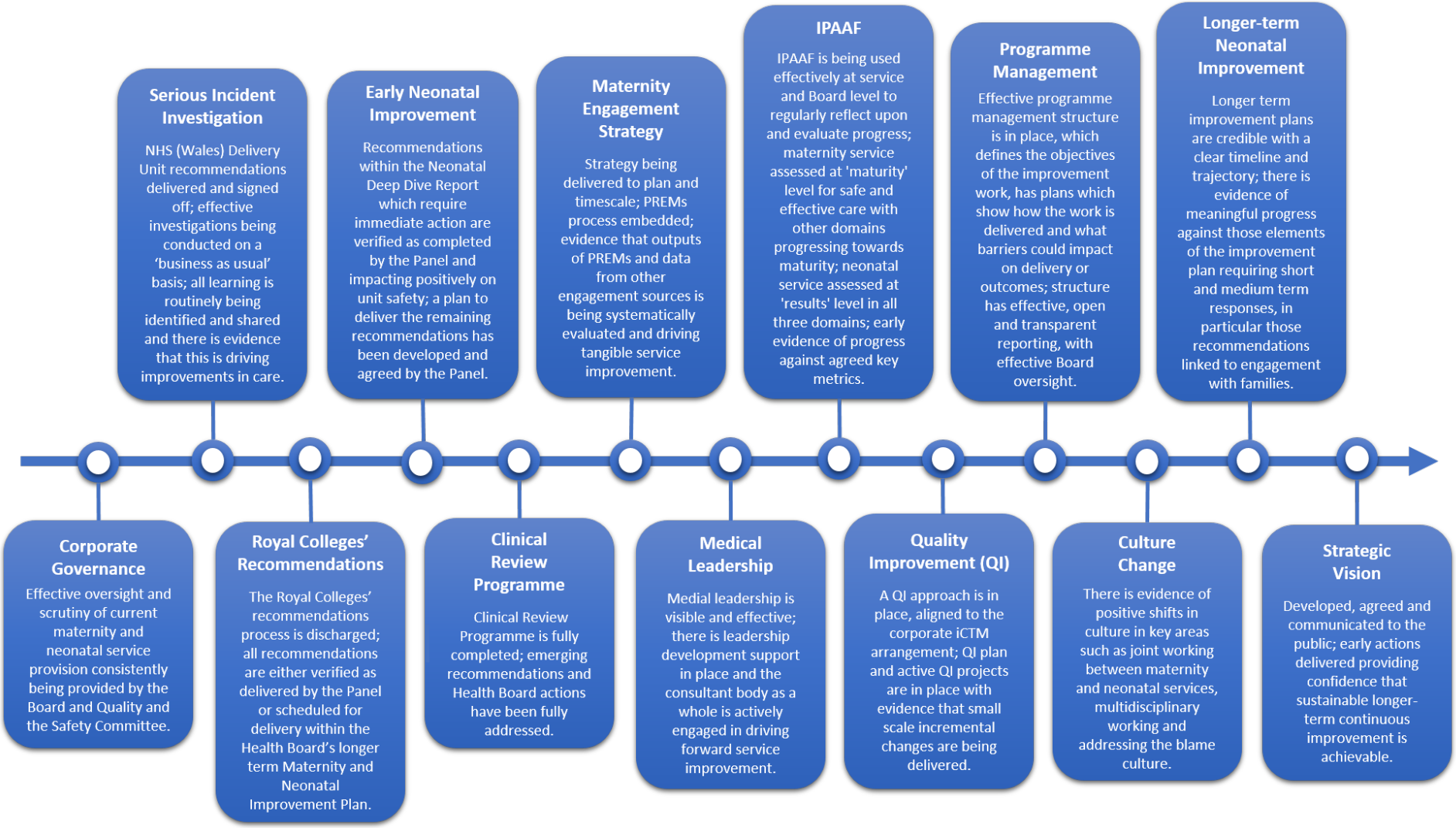
	Improvement Needed	Agreed Minimal Intervention	Position
3.2	Extra consultant time needs to be provided to allow for a consultant of the week pattern from 09:00 - 17:00. All consultants who cover the unit on call should have a minimum of four neonatal service weeks per annum.	• Review of medical workforce conducted following the deep-dive Escalation with associated action plan.	**Complete**
3.9	There needs to be an expansion of clinical pharmacist resource dedicated to the neonatal service, including capacity for networking to develop expertise and exemplar practice within the Neonatal Unit.	• Adequate time provision for pharmacy review of babies within the neonatal unit and those requiring prescribed medication in other areas including babies receiving treatment on the postnatal ward. • Protected, allocated pharmacist time for supporting education and training for all staff involved in prescribing and administering medication within neonatal care. • Protected, allocated pharmacist time for both quality assurance (e.g. audit) and improvement initiatives. • Pharmacy oversight of all prescriptions regardless of length of stay. • Monthly drug chart audits to date. • Ensure robust mechanism in place which includes pharmacy input into all Datix reviews of prescribing/ medication administration errors to date. • Pharmacy input into MDT reviews of babies transferred out for uplift of care to date.	**Complete**

	Improvement Needed	Agreed Minimal Intervention	Position
5.1	The clinical team must ensure completeness and accuracy of Neonatal Unit data.	• Senior clinicians to review neonatal data to ensure internal assurance can be provided to the Board and its Committees. • Neonatal data should feature within consultant, nursing and MDT meetings to ensure data being used by the service is accurate and have appropriate narrative. • Clear roles are identified with responsibility for ensuring that data is accurate and available in a timely manner.	**Work in Progress**
7.1	Communication with families on the Neonatal Unit must be timely, open and honest and comprehensively documented.	• All families must be spoken to prior to transfer of baby to the neonatal unit and this should be recorded in the notes – where this is not possible due to condition of mother and unavailability of family members this should be clearly documented. • All conversations with the family should be clearly documented on a separate sheet within the notes.	**Work in Progress**
7.6	Documentation standards must be improved in line with GMC/NMC requirements and there must be senior medical oversight of discharge summaries.	• Standards for documentation to be agreed in line with GMC/NMC guidance. • Discharge summary audit to be developed and undertaken by senior medical staff and reported within documentation audit results. • Regular monthly document standards audit being undertaken and reported.	**Complete**

10 Appendix D – The Health Board's Maternity and Neonatal Improvement Roadmap



11 Appendix E – Conditions for Sustainability



12 Glossary of Terms

Abbreviation	Term
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.