GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 4.1** **31 July 2019**

University Health Board Report
UPDATE ON MATERNITY SERVICES

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Purpose of the University Health Board Report
The purpose of this report is to provide the Board with an update on Maternity services. An update on actions taken since the last Board meeting and the known related implications of the special measures arrangements to date is summarised in this report.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within its approved 3 Year Integrated Medium Term Plan 2019-2022 and the related organisational objectives aligned with the 'Quadruple Aim' described within 'A Healthier Wales' (Welsh Government, June 2018) these objectives in summary are: • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future. • To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report focuses on all of the above objectives.
Supporting evidence	Appendix 1, Maternity Improvement Action Plan – new format and Assurance Framework. Appendix 2, Completed Action Assessment as of 14 July 2019. Appendix 3, Maternity Programme Governance Structure. Appendix 4, Womens experience surveys Appendix 5, Incident Newsletter: 3/7/2019 & 10/07/2019

Engagement – Who has been involved in this work?
Maternity Services Management Team and Clinical Staff; Patient Care and Safety Team

University Health Board Resolution to:							
APPROVE		**ENDORSE**		**DISCUSS**	√	**NOTE**	√

Recommendation	The Health Board is asked to: • **DISCUSS** and **NOTE** the reviews currently being led and/or supported by being external bodies.

Summarise the Impact of the University Health Board Report	
Equality and diversity	There are no specific implications relating to equality and diversity within this report.
Legal implications	The focus of the reviews compliment the Board Assurance Framework and the Health Board's Standing Orders.
Population Health	Equity is one of the tenets of quality in its broadest sense and will be better served by the implementation of any recommendations made as part of the review process contained in this paper.
Quality, Safety & Patient Experience	This report relates to the way in which quality, safety and patient experience is being externally reviewed, the recommendations of which and should therefore influence the design and delivery of the Board's strategic objectives.
Resources	The resource implications resulting from any recommendations will require full attention within services and directorates, and corporates. Implications should be considered via clinical business meetings, included in risk registers where appropriate and detailed within directorate integrated medium term plans.
Risks and Assurance	Recommendations resulting from external reviews should enable greater transparency and rigour in relation to the articulation of risk and assurance at all levels within the Health Board.
Health & Care Standards	Health & Care Standards are referenced throughout the core business of the Quality Safety & Risk Committee www.wales.nhs.uk/siteplus/documents/1064/Easy%20Read%20Standards%20FINAL%20December%202010.pdf
Workforce	There are no new implications associated with this report
Freedom of information status	Open

UPDATE ON MATERNITY SERVICES

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to provide the Board with an update on Maternity services, following the publication by Welsh Government on 30 April 2019, of the external review undertaken by the Royal College of Obstetricians and Gynaecologists (RCOG) & Royal College of Midwives (RCM).

2. BACKGROUND / INTRODUCTION

Background

In November 2018, the Maternity Improvement accountability structure was created to ensure rigour towards the oversight of the programme of improvement. On the appointment of the new Executive Director of Nursing, Midwifery and Patient Care in April 2019 and following the publication of the above reports, it was agreed that a robust programme management infrastructure be applied with a dedicated team to deliver the recommendations as set out within the external reports.

The Maternity Improvement Action Plan **(Appendix 1)** was redesigned in May 2019, when the Director of Nursing, Midwifery and Patient Care became the Senior Responsible Officer (SRO) / Lead Executive for the Maternity Services. The new action plan format constructs a plan that is divided into six key domains all containing a complete range of recommendations found in the RCOG/RCM Report, the Consultant Midwife Report, Delivery Unit and Healthcare Inspection Wales (HIW) Inspection Reports. The Working Groups and their leads are as follows:

- Quality and Governance – Associated Director Quality and Patient Experience
- Leadership and Culture – Deputy Director of Workforce and OD
- Education and Learning – Head of Organisational Development.
- Women's Engagement and Experience – Consultant Midwife
- Board –Director of Nursing, Midwifery and Patient Care
- Strategy and Planning – Assistant Director of Planning and Partnerships **(Appendix 2)**

The Programme Director will provide a weekly exception report on status changes to the action plan and table these reports at the Maternity Improvement Board. This will be monthly following the Maternity Assurance Board where progress from the working groups will be formally governed. **(Appendix 3)** details a 6 month look back of the achievement of the plan to date.

Independent Maternity Services Oversight Panel (IMSOP)

The IMSOP continues to work closely with the Health Board and has undertaken several site visits to date.

The first formal meeting of the panel is planned for 22 July; the Executive Director for Nursing, Midwifery and Patient Care and the Programme Director will present actions taken to date, along with improvements and work in progress.

The IMSOP has been appointed by Welsh Government to oversee the programme of improvement and transformation of maternity services, to provide advice and support but also to add rigour and challenge to the organisation as it responds to the recommendations of the RCOG and RCM.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Midwifery Staffing

The current historically agreed Midwifery establishment is 148.8 Whole Time Equivalent (WTE), with a funded establishment of 141 WTE. There is currently an agreed rostered establishment of 132 WTE based on a recent assessment by the Support Head of Midwifery, agreed at the Maternity Improvement Board on the 17 July 2019. The budget for Obstetrics & Gynaecology (O&G) has yet to be set for 2019/20.

Maternity services continue to report a vacancy rate of 14 WTE, this is based on the budgeted establishment from the former Cwm Taf service model (two obstetric units at 148.8 WTE). Work is underway with Birth Rate Plus (national workforce tool for maternity services across the UK) to establish the correct staffing requirements to provide an obstetric model of care in Prince Charles Hospital (PCH) with an estimated birth rate of 3,200 births per annum, a free standing midwifery led unit in Royal Glamorgan and community midwifery services. This will be completed in August with a planned report feedback at the end of September 2019. Currently the unit in PCH is established based on expert professional judgement by the Head of Midwifery and the senior midwifery team.

Sickness (primarily Long Term Sickness (LTS) remains high at between 11%, with stress the highest cause of sickness – factors such as a significant service change and the negative impact of the RCOG report contribute to this. Occupational health are supporting individual members of staff and the HR team are working with the Directorate to ensure appropriate application of the absence policy.

In response to the most recent round of newly qualified Midwifery recruitment activities our Head of Midwifery reported to the Maternity Improvement Board on the 17 July, that 20 Midwives have been offered posts within CTMUHB.

It must be recognised however, that less than half of these numbers opted to work within CTMUHB as their first choice – a robust supportive preceptorship programme is absolutely key to ensure retention of these new Midwives.

Medical Staffing
The Clinical Director for O&G has resigned, which includes the clinical lead for governance role. There is an advert being placed to recruit internally across CTMUHB.

Currently there are 4 WTE Consultant vacancies, three posts have been recruited into and are due to commence over the next 3 months. We have received a Consultant resignation active from July 2019. The Directorate are currently writing two Job Descriptions focussing on what the service requires. There are three long term Consultant locums supporting the service covering the service gaps.

There is 1 WTE vacancy at Middle Grade level in the service, with a long term locum in situ. However, the Directorate has received two resignations, and will have gaps from August 2019. An advert is currently live and are seeking further long term locum support.

There is currently 1 WTE gap due to maternity leave at the junior tier. The Directorate has 1 WTE over establishment, as agreed, to support Deanery training. The Directorate has secured a long term locum due to commence imminently.

All Clinical Leads are now agreed and active within their roles

Women's Experience
Women were being surveyed each week by a member of the PALS team and have provided feedback since 2 April on their inpatient experience. The majority of women are reporting a very good experience which is really encouraging, although some women are reporting a poor experience, mostly by night, related to the unprofessional behaviour and attitude of some Midwives. As a result of this negative feedback, we have increased the surveys to twice a week. All feedback is shared with the midwifery teams and our women's experience midwife visits women the following day to gain a deeper understanding of concerns raised; comments received are attached at **Appendix 4.**

The Executive Director of Nursing, Midwifery and Patient Care has written to all midwives recently, reminding them of their professional behaviours and responsibilities in providing safe care. This was followed up by a face to face meeting with groups of midwives, nursery nurses and health care assistants to reinforce the message.

Governance Framework in Maternity Gynaecology & Integrated Sexual Health Services
One of the key recommendations within the RCOG / RCM report was to develop an effective governance framework within the unit which has been achieved. From June 2019, the new Governance arrangements have commenced with separate clinical forums and quality and safety groups and a monthly Quality, Safety and Risk Forum.

These governance arrangements have been shared with Welsh Government and the Independent Maternity Services Oversight Panel.

As a relatively new structure which is currently embedding into the Directorate, the full potential of these forums and meetings have yet to be realised. However, the initial meetings and forums have recognised the importance of a multi-disciplinary approach to risk management to ensure that risks are identified, assessed and prioritised and ensuring appropriate mitigating actions are taken. There has been very positive engagement from across the teams and Directorate, whilst the staff from Princess of Wales Maternity & Gynaecology have been actively committed to integrate themselves into the groups & forums.

Risk Register

The risk register is under a full scale review to ensure that all risks are underpinned by updated risk assessments and an update was presented to the Maternity Improvement Board (MIB) on the 17 July. The completed Risk Register (RR) will be presented to the August MIB, following Directorate sign off and to the Health Board in September. The Quality, Safety and Risk Committee will have the opportunity to scrutinise the RR at its September meeting. Our high level risks and mitigation are outlined below, which may change following our RR review.

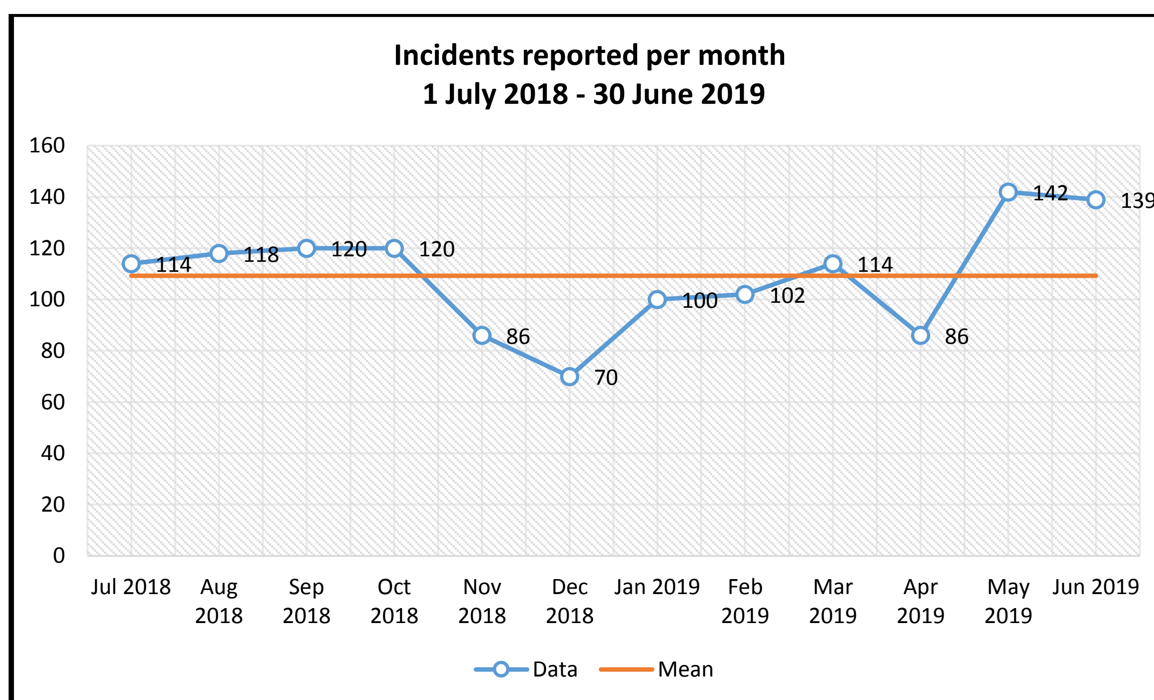
Risk	Mitigation
1. Non-compliance with Gap and Grow Policy – increasing risks of stillbirths	Increase training compliance, introduce a new fetal surveillance midwife role to support and monitor training
2. Obstetric Theatres non-compliance with National Standards - Cause: Non-compliance with theatre staffing standards resulting in increased risk to women	Increase theatre staffing to cover theatres and business case developed for revised staffing compliant with national standards
3. Capacity of maternity unit in PCH – impact of providing a safe & timely services to women. Risk of poor experience.	Daily acuity of women, business continuity managed by seeking support from POW, currently discussions with the region in relation to flows. (*Requires reduction in intervention rates)
4. Complaints management – back log of complaints due to the increased concerns/publicity into maternity services in Cwm Taf Morgannwg. Poor experience for women	Delegation of complaints out to the senior management team

Review of the 43 cases (as identified through the RCOG/RCM report)
A 'make safe' report led by the Lead Risk Midwife was presented at the Maternity Improvement Board in June 2019, updating the board on the key safety interventions and audits that are now in place. Learning and reflection is embedded into practice via the new clinical governance infrastructure. Weekly clinical case reflection sessions now take place on labour ward with good multidisciplinary attendance.

The IMSOP are currently devising a clinical review strategy which will incorporate a review of the 43 initial cases and a further look back (how far, to be confirmed) depending on their initial findings. It is likely that the IMSOP will also review the work undertaken at the time of the Health Board deep dive exercises into further cases.

It is regrettable that the clinical reviews have been delayed, due to a lack of information in the Health Boards database. This is now being addressed and more resources have been re-directed to ensure the database is updated, taking into account information governance requirements.

Clinical Incidents
Current Serious incidents – reportable to the Welsh Government since October 2018 - there are currently 8 Serious Untoward Incidents (SUI's) under investigation which are at various stages of progress. The following is a summary for June with a full report attached.



Maternity Incidents June 2019

118 Incidents reported
- 131 Patient Safety Incidents
- 4 Non Patient incidents

Status of incidents
- 3 in the holding Area
- 47 investigations in progress
- 85 investigations completed

Incident categories
- 130 No/Low harm
- 5 Moderate harm

Moderate harm incidents;
- Needle stick injury
- Baby born below 10th centile, admission to the neonatal unit
- Shoulder dystocia
- Birth Trauma, scalpel cut to head at caesarean section
- Unplanned admission to the neonatal unit and transfer by CHANTS to Singleton Hospital

Action being taken to review and action incidents

Weekly incident meetings held in Prince Charles Hospital (PCH) and fortnightly in Princess of Wales Hospital (PoWH) attended by the Multidisciplinary team. The location of the meetings have been changed to the labour ward multi-disciplinary room which has enabled clinicians working to attend for some or all of the meeting.

Attendance of these meetings has increased vastly from a small cohort of the same individuals to 15 members at the last meeting which included midwives and student midwives.

Share the learning

- Incident review newsletter with three action points of the week **(Appendix 4)**
- Immediate feedback to individual that reported the incident through the Datix system when incident is closed
- Learning and cases shared at the Directorate Governance Day
- Individual staff positive feedback letters following case review.

Monitoring themes and trends

- Continuous assessment of themes and trends occurs within the incident meetings to ensure actions that have been put into place are effective and sustained.
- Incident trends will be an agenda item within the labour ward/antenatal/postnatal forum to ensure actions required are implemented and monitored.
- Robust audit programme is in place to monitor and review the actions required.

Maternity Improvement Board

The Maternity Improvement Board met on the 18 July and considered a number of key themes and priorities relevant to the improvement programme.

- The need to develop outcome measures to track improvement.
- Revision of the Terms of Reference and membership of the MIB and Maternity Assurance Board.
- Consideration to appoint a Freedom to Speak Up Guardian (or similar)
- The operating model of the programme and work stream contributions.
- Regional flows and capacity.
- Clarity over the high risk issues in the plan and how these were being prioritised e.g. National Theatre Standards, women's experience of the emergency gynaecology service and the Gynaecology Day Assessment Services business case, accommodation issues for staff.
- The tabling of a key themes report highlighting the six Key Performance Indicators (KPI's) for maternity previously tabled at the Maternity Assurance Board

4. RECOMMENDATION

The Health Board is asked to:

- **DISCUSS** and **NOTE** the updates contained in this report.

Freedom of information status	Open