INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL

Cwm Taf Morgannwg University Health Board

Quarterly Progress Report
Spring 2020

The Independent Panel was established by Welsh Government in response to the findings of an independent review of maternity services in the former Cwm Taf University Health Board

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FOREWORD

On 30 April 2019, following the publication of a review conducted jointly by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, the Minister for Health and Social Services announced that he was placing maternity services in the former Cwm Taf University Health Board in ‘Special Measures’.

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

The Panel is currently required to report progress to the Minister on a quarterly basis. This report, the third to be published to date, covers the period of January, February and March 2020.

Mick Giannasi (Chair)

Cath Broderick (Lay Member)

Alan Cameron (Obstetric Lead)

Christine Bell (Midwifery Lead)

Cwm Taf Morgannwg University Health Board
Independent Maternity Services Oversight Panel

Mick Giannasi (Chair) is the Chair of Social Care Wales. He has extensive senior leadership experience and was formerly the Chair of the Board of the Welsh Ambulance Service NHS Trust, a Welsh Government Commissioner for Isle of Anglesey County Council and the Chief Constable of Gwent Police.

Cath Broderick (Lay Member) is an Honorary Fellow of the Royal College of Obstetricians and Gynaecologists and the author of the 2019 report, *Listening to Women and Families about Maternity Care in Cwm Taf*. She has extensive experience in patient and public engagement and supported the response to the Kirkup Inquiry in Morecambe Bay.

Alan Cameron (Obstetric Lead) has 26 years' experience as a Consultant Obstetrician and has recently been appointed as the National Clinical Lead in Obstetrics and Gynaecology for the Scottish Maternity and Children Quality Improvement Collaborative.

Christine Bell (Midwifery Lead) has over 30 years' experience working as a midwife in England, ten of those as a Head of Midwifery and is a designated Midwifery Assessor with the Royal College of Obstetricians and Gynaecologists.

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1 EXECUTIVE SUMMARY

1.1 COVID-19

As the Panel began to draft its Spring 2020 Quarterly Progress Report, the scale and impact of the threat associated with the COVID-19 outbreak was just beginning to emerge. It was also becoming increasingly apparent that the NHS was about to face the most significant challenge it has faced in its 72 year history. For that reason, the Panel took the opportunity to review its working practices in consultation with the Health Board and colleagues in the Welsh Government.

Childbirth will continue regardless of restrictions elsewhere in our lives and the safety and welfare of mothers and their babies remains as important in these difficult times as it ever has been. As such, it was agreed that the Panel should continue to provide a measured degree of oversight and support to the Health Board's improvement journey, albeit much reduced during this period.

However, the safety and welfare of the public, the NHS workforce and those the Panel works with is paramount. Consequently, adjustments will need to be made to reflect government advice around social distancing and restrictions on travel. Most importantly, the Health Board needs space to get on with the vital task of preparing for and responding to the increased demands which will inevitably be placed upon it.

In the short term, the Panel is looking at ways in which it can continue to discharge its terms of reference in a proportionate and risk-assessed way by reducing the administrative burden on the Health Board and optimising the use of home working, video conferencing and other more interactive communication tools like webinars and live blogging.

Women and their families lie at the heart of the improvement process and the Panel will work in the coming weeks to find different ways of ensuring that the important two-way conversation which has been started can continue. The Panel's clinical review work, which has now started in earnest, will remain a priority, albeit that the pace of progress may be impacted if independent review team members are called up into frontline operations.

A more detailed statement setting out how the Panel is responding to the current situation and the principles on which it has based its decisions is attached at *'Appendix I'*.

1.2 SUMMARY OF EARLY PROGRESS

When the Panel last reported in January 2020, it concluded that the Health Board was making good progress in addressing the Royal Colleges' recommendations and it was cautiously optimistic that longer-term sustainable improvement in maternity services would be delivered as the programme of work matured.

In particular, there was evidence of incremental progress against the 79 actions set out in the Maternity Improvement Plan and clear indications, supported by information from a range of internal and external sources that the service was improving more generally.

That improvement could be seen, not only in terms of the safety and quality of the care being provided, but also in the better experiences of the women and families using the service and in the way in which the service was being managed, led and governed.

The Panel reported that the foundations for continued improvement were now firmly in place; effective leadership, appropriate programme management arrangements, clear lines of governance and accountability and a genuine commitment to deliver change at Board and senior leadership levels. The Health Board was working collaboratively with the Panel and other stakeholders to deliver its Maternity Improvement Plan[1] within an environment of scrutiny and challenge.

The Health Board had also recognised that governance issues which had been identified extended beyond maternity services and was in the early stages of delivering a wider organisational development plan, focusing on leadership development and cultural change.

Although progress was undoubtedly being made, the Panel reported that there was still much to be done and called for an increase in pace, cohesion and administrative discipline. There were also issues, in particular the ineffective management of complaints and concerns, which were impacting on public confidence and needed to be addressed urgently at an organisational level.

The Panel identified a number of areas where it expected to see progress by the time it next reported, including further development of the Integrated Performance Assessment and Assurance Framework and further development of the Maternity Improvement Plan to include clearer milestones and targets.

Those issues and a summary of the progress which has been made against them are set out in more detail in Section 7 of the report.

1.3 FURTHER PROGRESS AGAINST THE MATERNITY IMPROVEMENT PLAN

Building on those solid foundations, the Panel is pleased to report that the Health Board has made **further incremental progress** during January, February and March 2020.

As a result, the Panel believes that the Health Board is now **firmly on track**, not only to deliver against the Royal Colleges' recommendations, but also, in time, to deliver a maternity service which they, their staff and their communities can be proud of.

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[1] The Maternity Improvement Plan is a consolidated action plan which contains 79 actions which address the seventy recommendations emerging from the Royal Colleges' review and nine other recommendations which emerged from associated internal reviews.

That is not to suggest that the job is done and further challenges and obstacles will undoubtedly materialise along the way. However, in the Panel's opinion, the Health Board now has the right resources, the right mechanisms and the right people in place to deliver the continuous improvement which is necessary to achieve that.

The Panel's main concern at this time of great uncertainty is whether the Health Board will be able to maintain the longer-term focus and commitment that is now needed to build upon the solid platform which has been created. Those concerns, are explored in further detail in Section 7 of the report.

During the period under review, the Panel has assessed evidence which provides them with reasonable assurance that a further 16 recommendations have been delivered since they last reported, bringing the total now completed to 41. This includes the following developments:-

- the bereavement service has been reviewed and improvements have been made to ensure that appropriate support and counselling is available for all families, albeit that a Task and Finish group has now been set up by the 'My Maternity My Way' forum to co-produce further enhancements;

- the maternity Governance and Risk team has now been appropriately resourced to ensure that workloads are manageable and that Datix (a system for recording health and safety related incidents) records are reviewed, graded and actioned in an appropriate and timely manner;

- all Independent Board Members have now been trained in the implications of the Corporate Manslaughter and Corporate Homicide Act 2007 to better understand their role in ensuring the safety of services provided by the Board;

- a mandatory training programme (including training in CTG, PROMPT, GAP and GROW[2]) has been designed and delivered to all medical and midwifery staff and high levels of compliance have been achieved[3].

That means that the Health Board has now delivered over half of the 79 recommendations in the Maternity Improvement Plan with the remainder work in progress.

That is a significant milestone, particularly as many of the recommendations which have been delivered, such as the revised clinical governance framework and the clinical audit programme, are fundamental building blocks for the delivery of others.

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[2] See glossary of terms in Section 11 of the report.

[3] A training plan was designed which would have achieved full compliance by 31 March 2020. However, training was suspended in mid-March due to the COVID-19 response and a small number of medical staff at the Prince Charles Hospital who were due to be trained at the end of March will now receive their training once normality has been restored. There are also a small number of medical staff at Princess of Wales Hospital who have still to complete their training, albeit that falls outside the Panel's terms of reference. Notwithstanding that, the Panel considers that the action which RCOG recommended has been fully delivered.

It is also important to emphasise that although they are not yet ready to be finally signed off, substantial progress has been made against a number of the 38 remaining recommendations. For example:-

- the 'Maternity Vision' (a plan which sets out long term strategic aims aligned to the all-Wales Maternity Vision) has been developed and is now out for consultation with a range of stakeholders including women and families representatives;

- the leadership, mindfulness and corporate values training programmes (which are part of the wider organisational development plan) are being rolled out and the level of attendance and participation has been encouraging.

Over the last three months, the Panel has also re-assessed a number of recommendations which were signed off in previous quarters to ensure that progress has been sustained and that change has become embedded in practice. That includes, for example, further checks around consultant availability and response times and confirmation that key members of staff are routinely participating in governance related meetings and events.

In addition, a 'triangulation' exercise was undertaken following the publication of the Healthcare Inspectorate Wales (HIW) report of the three-day unannounced inspection at Prince Charles Hospital in November 2019, to provide assurance that the issues which were identified in that report had been addressed.

Despite the obvious progress which has been made, there are a small number of recommendations against which the Panel would have expected to see more progress and these will be the subject of renewed focus in the next period. In particular:-

- whilst the Birthrate Plus® review has confirmed that existing staffing levels are appropriate, the Panel awaits the development of a longer term workforce action plan which shows how those resources will be optimised (for example, by reducing sickness and reducing the use of overtime) and how deployments will be adjusted to reflect changing patterns of demand and new ways of working;

- whilst progress has been made in ensuring that policies, protocols and guidelines are readily available and accessible to staff, a significant number of policies now require review and further updating. A prioritised schedule has been agreed and the Panel will be monitoring its implementation during the next period.

A more detailed assessment of the progress which has been made over the last three months in delivering against the Maternity Improvement Plan and more specifically, against the Royal Colleges' recommendations, is set out in Section 8 of the report.

1.4 OTHER INDICATIONS OF FURTHER IMPROVEMENT

Over the past three months, there has been less external review and inspection activity of the Health Board's maternity and neonatal services than in previous reporting periods. As such, there has been less opportunity to triangulate the Panel's assessment against other forms of evidence.

There is however, softer intelligence which supports the Panel's assessment that services are improving and that this is having a positive impact on the experience of women and families. For example, the twice weekly surveys conducted by the Health Board's Patient Advice and Liaison Service (PALS) have continued to demonstrate consistently high levels of satisfaction from women and families using the services at Prince Charles Hospital.

In every improvement journey there are symbolic events which validate the perception that a corner has been turned; they cannot always be quantified or turned into a performance metric but they do provide a real sense that things are changing for the better. The formal opening of the Tirion Birth Centre at the Royal Glamorgan Hospital on 09 March 2020 was one such event.

Not only are the state-of-the-art facilities designed specifically around the needs of women and their partners, the strong bonds which have been built between the staff and the women who have given birth there are self-evident and powerful. That is in stark contrast to the situation reported by the Royal Colleges just over 12 months earlier.

Since its creation in March 2019, the Tirion Birth Centre has become a hub for women, babies and families and a significant number turned out to join the staff in celebrating its early success. Indeed, the line of parked push chairs and buggies extended a long way down the hospital corridor! Some families spoke passionately in the opening ceremony about the way they had been cared for by staff and there was a palpable sense of pride and shared ownership which was incredibly heart-warming for those members of the Panel who had the privilege of attending.[4]

The Panel acknowledges that in relative terms, Tirion is currently a small but nonetheless important part of overall service provision; however, it is seeing evidence of a similar shift in attitudes and relationships in maternity service settings across the entire Health Board area.

[4] *Due to the implications of COVID-19 on staffing capacity, the decision was taken by the Health Board's Gold Command to temporarily decommission Tirion Birth Centre at Royal Glamorgan Hospital from 19:00 on 19 March 2020 onwards. This situation will be kept under close review. The maternity staff from this unit have since been redeployed to support midwifery services at the other Health Board sites.*

1.5 INDEPENDENT CLINICAL REVIEW

When the Panel last reported in January 2020, the first phase of the Clinical Review Programme had just begun in earnest. The multidisciplinary teams of midwives, obstetricians, anaesthetists and neonatologists who are conducting the reviews had been inducted and trained in the use of the designated review tool. A pilot study had also been undertaken in order to 'test' the systems and processes which have been developed and to ensure consistency of approach.

Although steady progress was being made, there was some slippage, largely due to a lack of capacity in the Health Board to support the administrative processes which underpin the programme and a lack of preparedness to provide information and support to the women and families affected. The Panel was also concerned that the self-referral process was taking too long to finalise and there was a lack of rigour around the Health Board's administrative processes which was often resulting in re-work and duplication of effort.

Those issues were raised with the Health Board and in fairness, there was an immediate and positive response. The improvement team was re-organised in early January to provide more focused support to the clinical review process and additional capacity was provided to undertake the redaction of case notes and supporting papers.

In addition, the women and families database, which is critical to effective engagement, has been redeveloped in a more robust format while the self-referral process has also been agreed and signed off.

The new staff coming into the team, in particular the Lead Midwife, have brought new skills and insights to the programme and as a result, the support which is being provided by the Health Board is now more robust, timelier and more efficient. The Panel feels better supported in this regard and as a result, the pace has been stepped up and a significant amount of progress has been made.

In the meantime, three more multidisciplinary clinical review teams have now been recruited, trained and inducted, bringing the number now available to six. This has enabled the second tranche (babies who, sadly, were stillborn) to be commenced and the women whose care is about to be reviewed are being contacted to enable them to tell their story if they wish to do so.

In addition to the recruitment of additional multidisciplinary clinical review teams, a Quality Assurance Team and a Quality Assurance Panel have been established to oversee the individual reviews and to draw out the key themes and issues which will form the basis of reporting back to the Health Board. The Quality Assurance Team will also ensure consistency of approach and ensure that the findings are reported back to women and families in a spirit of openness and transparency.

The COVID-19 outbreak will bring new challenges to the clinical review work and the Panel is having to adjust its working practices accordingly. Although the clinical review methodology has been designed to operate in a virtual environment, it is important to recognise that the pace of progress will be affected if clinical review team members or Health Board support staff are called upon to support front line operations.

A more detailed summary of the further progress which has been made in implementing the Clinical Review Strategy is outlined in Section 4 of the report.

1.6 Engagement With Women and Families

When the Panel last reported in January 2020, it concluded that the Health Board was making good progress in improving the way it engages with women and families. The Panel's Lay Member had played a pivotal role in leading and coordinating activities in the initial stages of the improvement process. However, she was now increasingly able to step back into an advisory role with the Health Board taking stronger ownership for the leadership and strategic direction of the engagement and communication element of the Maternity Improvement Plan.

The early progress has been consolidated during the last quarter and the Health Board has made further steps forward which are clearly starting to change the nature and tone of the relationship between the people who use the service and those who currently deliver it.

The initial engagement programme has now been completed with the successful delivery of a third event in Bridgend and there are clear plans emerging for activities over the next 12 months. In the meantime, those who are leading the programme have grown in confidence and ability and are now starting to set their own agenda.

There is still much to do, particularly to ensure that the learning from engagement is reflected in service design and delivery and there are still residual issues about the management of complaints, concerns and feedback. However, in broad terms, the Health Board is in a fundamentally different place than it was a year ago in the way it engages and communicates with women and families.

Following the most recent community engagement event in Bridgend, which was the best attended and most productive yet, one of the mothers who attended wrote:-

> *"I just wanted to thank you (all) for your time and for actually making my thoughts, feelings and opinions feel valued and listened to. It really helped me and lifted my mood. It's the best thing I've done so far in 2020, coming to the session today. Thank you again".*

That view is typical of the views expressed by others and reflects a considerable transition from the experiences of those families who shared their concerns during the Royal Colleges' review.

The ground work had now been completed which has created the conditions for further development in this area. The Health Board has completed its analysis of the feedback which has been gathered from the initial phase of engagement and more detailed plans will emerge during the coming months. These plans will set out how the feedback which has been gathered in the initial phase will begin to drive changes in service design and delivery.

Ultimately, this will need to be reflected in the development of appropriate performance metrics within the Integrated Performance Assessment and Assurance Framework (IPAAF).

Looking ahead, the Panel will be monitoring and supporting the delivery of the 2020/21 Engagement Plan, although expectations will need to be realistic given the impact of the COVID-19 situation on the NHS and on the ability of women and families and partner agencies to participate. There will also be a continued focus on the delivery of the maternity services element of the corporate complaints and concerns action plan, where more work is still required.

A more detailed summary of the progress which has been made in this area and some of the work which remains to be done is outlined in Section 5 of the report.

1.7 Development of the IPAAF and the Maternity Improvement Plan

Both the Panel and the Health Board are fully committed to the Integrated Performance Assessment and Assurance Framework (IPAAF) model. The IPAAF is an important element of the oversight process because it enables performance improvements to be monitored, assessed and reported objectively, based on evidence and outcomes.

It will also, in the longer term, provide the means by which the Health Board will be able to gain the assurance it needs that the maternity and neonatal services it provides are safe and effective, well managed and well lead with a strong focus on the experience of the women and families they care for.

When the Panel reported in January 2020, it expressed disappointment about the pace with which the IPAAF was being developed. There was also a lack of tangible progress in enhancing the existing Maternity Improvement Plan to include clearer milestones, targets and deliverables.

In January, additional resources were brought into the Maternity Improvement Team and there were changes in structure which provided increased capacity and greater focus in key areas.

As a result, the Maternity Improvement Director has been able to focus more time and energy on developmental issues and to her credit, a significant amount of progress has been made in a relatively short period of time.

This culminated in a workshop being held on 09 March where broad agreement was reached about the metrics which will be used to populate the three performance domains of the IPAAF and the methodology which will be used to make reasoned assessments against the various levels within the Maturity Matrix which has been agreed as the basis for reporting progress to Ministers.

Although the IPAAF will still require further refinement and incremental adjustment over the coming months, this represents good progress and the Panel is satisfied that a workable performance assessment and assurance framework is now in place.

The significance of this is that for the first time, the Health Board has now been able to self-assess against the Maturity Matrix and has concluded that the current position is as follows:-

Figure 1: *Maturity Assessment – April 2020*

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

The Panel has reviewed the Health Board's rationale for the assessment and agrees with the conclusions which have been reached, i.e. the Health Board now making 'Early Progress' and moving towards 'Results' in each of the three performance domains.

A more detailed explanation of the IPAAF, the Maturity Matrix and the rationale for the assessment is included in Section 6 of the report.

As well as making progress in developing the IPAAF, the Maternity Improvement Plan has also been enhanced to include clear timescales and milestones for delivery. Although the link back to the Royal Colleges' recommendations has been maintained, it is now a plan which is about delivering sustainable improvement over time, rather than simply about ticking off a long and sometimes overlapping list of actions.

A more detailed explanation of how the Maternity Improvement Plan has evolved is included in Section 6 or the report and a copy of the high-level plan showing milestones and timescales is included in *'Appendix G'*.

1.8 HEALTH BOARD RESPONSE

Over the past three months, the Health Board has continued to work constructively with the Panel to drive forward the improvement programme and despite all the other challenges which the organisation faces at this time, there remains a genuine sense of ownership at Chair, CEO and Board level. The improvement framework which has been put in place through the Maternity Improvement Board (MIB), the Maternity Improvement Team (MIT) and the three Project Boards continues to evolve and by and large it continues to work well.

There were capacity and capability issues in the MIT in the run up to Christmas 2019 and this was affecting the pace of progress. However, the issues were addressed quickly and positively by the Health Board through a restructuring of the team and bringing in additional capacity, particularly in support of the Clinical Review Programme.

Since the end of January, the MIT has been working at full establishment which has improved administrative efficiency and freed up the capacity of the Improvement Director to focus on developmental issues. This has enabled a number of important pieces of work to be progressed during the quarter, not least:-

- the agreement and sign off of the self-referral process;
- the redevelopment of the women and families database;
- further development of the IPAAF;
- the refresh of the Maternity Improvement Plan;
- the timelier presentation of evidence to the Panel;
- the delivery of another tranche of the RCOG recommendations.

The newly appointed Director of Midwifery took up her post in early January. This is the first time that the senior midwifery post has been offered at Director level and the benefits of that are already becoming apparent. The Director brings with her a wealth of experience and relevant insight which is already resulting in increased momentum, new ideas and a more strategic approach.

The appointment also means that the triumvirate of medical, clinical and managerial leadership is now in place on a substantive basis for the first time since the improvement programme commenced. It is noticeable that the leadership team is now behaving in a more cohesive way and is starting to take control of the improvement agenda with the MIT increasingly taking on a supporting role. That greater ownership is particularly welcomed.

In recent weeks, the Panel has become increasingly aware that it has not paid as much attention to the neonatal service as it has the maternity service.

An invitation has been extended to the Lead Neonatologist to attend the next formal Panel meeting to provide an overview of the service and this will now become an area of focus in the next reporting period, subject to the impact of the COVID-19 situation.

The Panel continues to work closely with the CEO to ensure that there is synergy between what is happening in maternity and neonatal services and the wider corporate improvement plan. In recent weeks, in addition to the roll out of the new operating model, a new corporate performance management framework has been published and the organisation's wider engagement and communication strategy is nearing completion. All of these things will help to ensure that the improvements which are being delivered in maternity services are sustainable in the longer term.

There has been some progress against the complaints and concerns action plan with a revised structure, additional resources and a new complaints and concerns policy being put in place during the last quarter. There are signs of improved performance, particularly in terms of improvements in the timeliness for new complaints and a reduction in the number of complaints which are re-opened.

However, recent feedback from women and families suggests that resolving longstanding historical complaints remains a problem and the Panel will continue to focus its attention on this issue during the forthcoming period. There are also challenges around the quality of responses being provided and it is encouraging to see the Director of Midwifery taking personal ownership of that in so far as maternity services are concerned.

In the conclusion to its previous report, the Panel identified eight areas where it expected to see the Health Board make progress during the first quarter on 2020. These are set out in Section 7 of the report together with a brief assessment of what has been achieved.

1.9 Summary of Conclusions and Next Steps

Building on the solid foundations identified in its earlier reports, the Panel believes that the Health Board has made **further progress** during the first quarter of 2020. In particular:-

- there is evidence of further delivery against the Maternity Improvement Plan;
- there are clear signs that the service is improving;
- the initial phase of engagement has been completed with positive outcomes;
- the Clinical Review Programme has now commenced in earnest;
- the Health Board continues to engage constructively in the process;
- the improvement framework which has been put in place is working well;
- the IPAAF and the MIB have been further developed;
- an initial baseline assessment has now been conducted;
- there is evidence of 'Early Progress' against all three of the IPAAF domains.

On that basis, the Panel believes that the Health Board is **now firmly on track**, not only to deliver against the Royal Colleges' recommendations, but also, in due course, to deliver a maternity service of which they, their staff and their communities can be proud.

There is still much work to be done and a number of 'next steps' actions have been identified which will provide the focus for the next period and be monitored through the assurance process, which is now well established. These actions are summarised in section 9 of the report.

The Panel's main concern at this time of great uncertainty is whether the Health Board will be able to maintain the longer-term focus and commitment that is now needed to build upon the solid platform which has been created.

1.10 RECOMMENDATIONS

In view of the progress which is being made and the ongoing commitment which the Health Board is showing to the improvement process, the Panel does not feel that it is necessary to make specific recommendations for the Health Board at this stage.

However, in view of the progress which is being made, the Panel is proposing that **the reporting cycle be extended to six months with the next report being due at the end of September 2020.**

The rationale for this recommendation is explained in further detail in Section 9 of the report.

2 PURPOSE AND FORMAT OF REPORT

The purpose of this report is to summarise the progress which the Independent Maternity Services Oversight Panel is making in discharging the terms of reference set for it by the Minister for Health and Social Services.

In particular, the report provides an ongoing assessment of the progress which the Health Board is making in delivering the improvements in maternity services which were identified as necessary by the Royal Colleges and other associated reviews. The report also provides assessments of progress against the clinical review and engagement elements of the Panel's work.

This is the Panel's third quarterly report which reflects developments and events which have occurred during January, February and March 2020. For ease of reference it is referred to as the Spring 2020 Quarterly Progress Report. It builds upon the previous quarterly reports which were published in October 2019 and January 2020. In the interests of brevity, background information and context provided within the first two reports is not repeated unless it is necessary to assist understanding.

In addition to highlighting those areas where clear progress has been made, the report also identifies the key issues and challenges which remain and the actions being taken by the Health Board and/or the Panel to address them. Necessarily, it touches upon wider organisational issues which are being addressed in order to ensure that the improvements which are being delivered in maternity services will be sustainable in the longer term.

The report is designed to be a public facing document. As far as is possible in a document of this nature, it is written in simple language which minimises the use of technical terms and detailed performance information. It is important to emphasise that the Panel and the Health Board are adopting an evidence-based approach and the conclusions which are set out in the report are supported by more detailed information and analysis. However, in the interest of keeping the report succinct, that supporting evidence may not always be outlined in full in the report.

The Health Board's programme and performance management arrangements are now beginning to mature and there has been further progress in developing the Integrated Performance Assessment and Assurance Framework (IPAAF) during the last three months. This is now starting to enable the Health Board to become more outcome focused in its performance management and corporate governance arrangements.

The development of the IPAAF has also enabled the Panel, for the first time, to provide an evidence-based assessment of where the Health Board currently is in terms of its improvement journey against the Maturity Matrix which has been developed as a means of assessing progress. This will become more sophisticated as the IPAAF evolves but having a baseline to work from is an important development. This is explained further in section 6 of the report.

The report is broken down into a number of discrete sections as follows:-

- **Section 3 (Background and Context)** summarises the background to the Minister's decision to place maternity services in special measures and explains very briefly how the Panel has been established to discharge its terms of reference. This section is intentionally brief, having been covered in detail in the Panel's previous reports;

- **Section 4 (Independent Clinical Reviews)** explains the progress which has been made in the last three months against the Clinical Review Strategy which was published alongside the firstly quarterly report in October 2019;

- **Section 5** (**Engagement with Women and Families)** provides an assessment of the progress which has been made by the Health Board as it continues to build its capacity and capability to engage with women and families who use maternity services and is beginning now to reflect that in service design and development;

- **Section 6 (Assurance Framework and Maturity Matrix)** outlines the progress which has been made in developing the Integrated Performance Assessment and Assurance Framework (IPAAF) which has been agreed between the Health Board and the Panel as the basis for assessing progress and current assurance levels. It also explains how the IPAAF underpins the Maternity Services Improvement Maturity Matrix and for the first time provides a baseline assessment of the Health Board's progress against the Matrix;

- **Section 7 (Health Board Response)** provides an ongoing assessment of the arrangements that the Health Board has put in place in response to the Minister's intervention and highlights areas where further development is necessary in order to optimise the potential for improvement;

- **Section 8** (**Assessment of Progress against the Maternity Improvement Plan)** provides the Panel's assessment of the further progress which has been made during the last three months in delivering against the 79 actions contained within the Maternity Improvement Plan (MIP) and explains how the MIP has evolved to include more defined milestones and delivery timescales;

- **Section 9 (Conclusions and Next Steps and Recommendations)** sets out the Panel's overall assessment and identifies what the Minister might expect in terms of delivery during the next reporting period.

In view of the progress which is being made and the ongoing commitment which the Health Board has shown to the improvement process, the Panel does not feel that it is necessary to make specific recommendations for the Health Board in this report.

There are, however, a number of areas where further action is required in the next quarterly reporting period in order to sustain and build upon the progress which has been made. These 'next steps' actions are highlighted within the report and will be progressed with the Health Board through the Panel's regular business cycle.

The report does make one recommendation for the Minister's consideration which relates to the timing and frequency of the progress reporting cycle. This is explained in further detail in section 9 of the report.

3 BACKGROUND AND CONTEXT

This section of the report provides a very brief summary of the background to the Minister's intervention, a short explanation of the role of the Independent Maternity Services Oversight Panel and an overview of the improvement framework which the Health Board has put in response.

This section has been kept deliberately brief because the background was explained in some detail in the Panel's Autumn 2019 Quarterly Progress Report which was published in October 2019. A copy of the report can be accessed here if further explanation is needed but in summary, the key issues are as follows.

In October 2018, as a result of growing concerns about the quality and safety of care being provided in the maternity units at the Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH), the Welsh Government commissioned an independent review by the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM).

The Royal Colleges' report, setting out the findings of their review, was published on 30 April 2019. It highlighted serious concerns about quality and safety, compounded by failings in corporate governance, dysfunctional relationships and inappropriate culture and behaviours.

A supplementary report which captured the stories of some of the women and families who had used the service painted a distressing picture of patient experience and service quality that was far short of an acceptable standard.

The Royal Colleges' report contained seventy recommendations for improvement, all of which were accepted by the Welsh Government and the Health Board. This included recommendations that a number of incidents which occurred between January 2016 and September 2018 should be subject to independent clinical review with a further look-back exercise to 2010, and potentially beyond, if necessary.

As a result of the Royal Colleges' findings and as part of a broader package of interventions, the Minister placed maternity services within the former Cwm Taf University Health Board in 'Special Measures'.

At the same time, the Minister appointed the Independent Maternity Services Oversight Panel to seek robust assurance from the Health Board that the recommendations within the Royal Colleges' report were being implemented in a timely, open and transparent way which placed women and families affected by the review at the heart of the process.

A copy of the terms of reference for the Panel can be found at *'Appendix A'*.

The Panel has developed a collaborative relationship with the Health Board from the outset in order to minimise any unnecessary bureaucracy and duplication of effort whilst maintaining an environment of robust challenge and scrutiny.

The Panel's business cycle is now well established based around a formal monthly Panel meeting attended by a range of stakeholders who have the status of participating observers[5]. This includes representation from the Community Health Council and the Trade Unions. Other agencies include the NHS Delivery Unit, Healthcare Inspectorate Wales and the Wales Audit Office[6].

The Health Board has responded positively and constructively to the Minister's intervention and has put a robust framework in place to deliver the improvements in maternity services which are necessary. This includes the appointment of a Senior Responsible Officer (SRO) at Board level, the establishment of a Maternity Improvement Board reporting directly to the Board via the Quality and Safety Committee and the creation of a dedicated Maternity Improvement Team which is project managing a Maternity Improvement Plan delivered through three, domain-based project groups.

The Health Board has also recognised that some of the underpinning challenges and issues identified by the Royal Colleges are broader than maternity services and has established an organisational development programme to redefine its corporate vision and values and to improve leadership and engagement at all levels from Board to operations.

Further information about the Royal Colleges' review, the Minister's intervention, the oversight process, the Panels' terms of reference and operating methodology and the Health Board's improvement framework can be found in Panel's Autumn 2019 Quarterly Progress Report.

[5] *Albeit the Panel acknowledges that its current operating methods may need to be adjusted over the coming months to reflect the impact of the COVID-19 situation.*
[6] *It should be noted that the Wales Audit Office officially changed its name to Audit Wales on 01 April 2020.*

4 INDEPENDENT CLINICAL REVIEW

The Panel's Clinical Review Strategy was first published in October 2019. It has recently been refreshed to reflect minor adjustments in terminology and process since the original document was produced, although the substance has not changed significantly. The revised document can be accessed here if further background information is required.

When the Panel last reported in January 2020, the first phase of the clinical review programme had just begun in earnest. The multidisciplinary teams of midwives, obstetricians, anaesthetists and neonatologists who are conducting the reviews had been trained and inducted and a pilot study had been undertaken in order to 'test' systems and to ensure consistency of approach.

The women whose care is being reviewed had been informed and invited to participate in the process if they wish to do so. It was confirmed that the Community Health Council (CHC) would be providing advocacy services to those women who wish to be supported through the process.

Although steady progress was being made, there was some slippage in the programme. This was largely due to a lack of capacity in the Health Board to support the administrative processes which underpin the Clinical Review Programme and a lack of preparedness to provide information and support to the women and families affected. The Panel was also concerned that the self-referral process was taking too long to finalise with a lack of rigour around the Health Board's administrative processes which was often resulting in re-work and duplication of effort.

Those issues were raised with the Health Board at Board level in mid-December and in fairness, there was an immediate and positive response. The Maternity Improvement Team was reorganised to provide more focused support to the clinical review process and additional capacity was provided to undertake the redaction of case notes and supporting papers.

The new staff coming into the team, in particular the Lead Midwife, have brought new skills and insights and as a result, the support which is being provided is now more robust, timelier and more efficient. The Panel now feels much better supported in this regard and as a result, the pace has been stepped up and a significant amount of progress has been made. At the same time, the women and families database, which is critical to effective engagement has been redeveloped in a more robust format while the self-referral process has also been agreed and signed off.

The COVID-19 outbreak will bring new challenges to the clinical review work and the Panel is having to adjust its working practices accordingly. Although the clinical review methodology has been designed to operate in a virtual environment, it is important to recognise that the pace of progress will be affected if clinical review team members or Health Board support staff are called upon to support front line operations.

The remainder of this section summarises the further developments which have taken place during January, February and March 2020.

4.1 Clinical Review Project Group

The Clinical Review Project Group is made up of the Panel's Obstetric and Midwifery Leads, representatives from the Health Board, the NHS Wales Delivery Unit and the Community Health Council.

The Project Group has overall responsibility for the running of the clinical review look-back exercise. It ensures that the clinical review teams are provided with the correct information to undertake the review and that women and families are offered the opportunity to participate in their review should they wish to do so.

The Project Group is meeting on a regular basis to project manage and refine the programme and is currently focusing on developing the format and design of the reporting and feedback process.

4.2 Induction Programme For Clinical Review Teams

Following the successful recruitment of independent obstetricians, midwives, anaesthetists and neonatologists at the end of 2019, a further two induction programmes have taken place in January and February. These have been led by the Panel's clinicians and supported by the Welsh Government and the NHS Delivery Unit. The aim of the induction programme was to ensure that the reviewers were fully aware of the background to the review and understood their role in supporting the review process. As a result, there are now six teams of highly skilled and experienced clinicians available to support the programme.

4.3 Clinical Review Programme

In previous reports, the Panel has explained how the clinical review work will be phased and delivered over time. That information can also be found in the Clinical Review Strategy which can be viewed here.

At the current time, the clinical review work is focused on around[7] 140 episodes of care which were provided between January 2016 and September 2018. This includes the 43 incidents which were originally identified in the Royal Colleges' review.

A pathway has been developed to explain to women and families how the clinical review process will work. A copy of the pathway is attached at *'Appendix B'* to the report.

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[7] It will be noted that the number of cases being reviewed is slightly lower than the number (circa 150) originally identified in the Autumn Quarterly Report. This is due to more accurate information increasingly being available which has resulted in a number of duplicates being identified. It is important to note that this figure may change as the clinical review work evolves and further information becomes available. Where additional cases are identified which meet the inclusion criteria, the women and families involved will be informed.

For the purpose of allocating the individual reviews to the six clinical review teams, the cases have been sub-divided into three categories as shown in the table below.

Figure 2: *The Clinical Review Categories*

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

All of the women whose care is being reviewed have now been contacted to make them aware and further, more specific information is being provided to them once their individual review is ready to commence. If other cases are identified as the work progresses, then the women and families involved will be informed accordingly.

At various times, the Health Board has provided a telephone and email service to offer information and support to those who are being contacted, although the level of take-up has been less than anticipated. That tends to suggest that the initial information which is being provided is meeting the needs of the women and families involved.

4.4 Feedback From The Pilot Exercise

During December 2019, January and February 2020 a pilot exercise was undertaken by three clinical review teams with a small number of test cases involving mothers who had complications before, during or after pregnancy, including admissions to ICU.

Feedback from the clinical review teams involved in the pilot exercise has resulted is some changes to the review tool to ensure that it is as robust as possible. In particular, feedback from the Neonatal Lead on the Quality Assurance Panel has led to the development of a more bespoke review tool for neonatal cases and this is now included in the revised version of the Clinical Review Strategy. This is a demonstration of the real value in the multidisciplinary approach which is being adopted.

4.5 Timeframes For Completion

As previously stated, it is not possible, at this stage, to make any predictions on how long the review process will take. The three clinical review teams involved in the pilot cases are now in the process of reviewing the remaining cases where mothers were admitted to ICU or required some other form of specialist input at some stage during their pregnancy.

The next cases being reviewed are those involving women and families whose babies sadly were stillborn. The Panel has begun writing to these families to advise them that their care is being reviewed and to invite them to participate should they wish to do so. The review of these cases commenced during late March.

4.6 Quality Assurance Panel

A Quality Assurance Panel has been established comprising the IMSOP Obstetric and Midwifery Leads, an independent Neonatologist and an Anaesthetist together with representation from the NHS Delivery Unit and the Community Health Council. The Panel met for the first time on 24 March 2020.

The role of the Quality Assurance Panel is, as its name suggests, to provide quality assurance both in terms of the process and the outcome of the individual clinical reviews. In order to discharge that function, the Quality Assurance Panel will independently review:-

- all the cases related to the care of mothers;
- those cases relating to stillbirths and neonatal mortality and morbidity where major issues around care were identified.

In addition, the Quality Assurance Panel will review a randomised proportion of the remaining cases in order to ensure consistency and accuracy of reporting.

This quality assurance process will inform individual feedback to women and families and the development of more generic recommendations to the Health Board.

4.7 Quality Assurance Team

A Quality Assurance Team has also been established comprising two senior midwives external to the Health Board. The role of the Quality Assurance Team is to provide support to the Quality Assurance Panel to ensure that there is consistency across the review process as well as identifying any areas where further detail is required from the review teams prior to discussion at the Quality Assurance Panel.

The Quality Assurance Team met for the first time on 16 March 2020 and the skills and expertise they bring in external reviewing are already having a valuable influence on the programme.

4.8 Post-October 2018 Serious Incidents

In addition to the ‘look back’ exercise, the Panel is also quality assuring serious incidents which have occurred in the Health Board since 01 October 2018. The Panel has carried out several reviews of those incidents and made recommendations back to the Health Board which are at various stages of implementation.

This process has now been developed on a more structured basis to include the involvement of the Neonatal Lead from the Quality Assurance Panel and representation from the Welsh Government and the NHS Delivery Unit. The most recent assurance exercise took place on 6 April 2020.

4.9 SELF-REFERRALS

The Independent Clinical Review Programme includes a process for reviewing cases which have been self-referred by women and families. This is based on a commitment which was made by the Minister at the time he announced the 'Special Measures' arrangements.

As the self-referral process has developed, it has become increasingly apparent that whilst all of the self-referral cases will need to be reviewed, not all of them will necessitate a full clinical review and not all of them need to be conducted independently. As such, the precise review methodology which is adopted in each case, will be dependent on the nature of the concerns raised and an understanding of the needs and wishes of the women and families involved, which will be based on individual consultation.

Regardless of whether individual self-referrals are suitable for clinical review or not, the Panel will continue to monitor each individual case to ensure that wherever possible, a satisfactory resolution is achieved which addresses the needs of the women and their families.

The Health Board has developed a process for managing self-referrals which was signed off at the formal IMSOP meeting in February 2020. The process provides clarity about which incidents are classed as self-referrals and explains how that information is cross referenced with other elements of the clinical review process. A pathway which was prepared to explain to women and families how the self-referral process will work is attached at *'Appendix C'* in poster format.

The Health Board is undertaking a triage exercise during March and April 2020 to identify the most appropriate resolution for each individual self-referral. The Health Board will be making contact with all families who have self-referred to understand their aspirations and involve them in the triage process.

The Health Board now reports to the Panel on a monthly basis, outlining the number of women and families who have made contact, the number of cases which have been triaged and an overview of the outcome in each case. Where a formal review of care is agreed with women and families on completion of the triage process, each case is discussed individually at a joint meeting between Health Board and the Panel to agree a way forward.

The Panel will then monitor the process to ensure that appropriate outcomes are achieved in a timely manner which puts women and families at the heart of the process. If it is agreed that the case necessitates a full independent clinical review the Panel will ensure this is reviewed within the appropriate category alongside the 2016-2018 look-back reviews.

5 ENGAGEMENT WITH WOMEN AND FAMILIES

In its Winter 2019 Quarterly Progress Report, the Panel concluded that the Health Board was making good progress in improving the way it engages with women and families. It was also pleased to report that having played a pivotal role in leading and coordinating activities in the initial stages of the improvement process, the Panel's Lay Member was increasingly able to step back into an advisory role with the Health Board taking on more and more ownership.

That early progress has been consolidated during January, February and March 2020 and the Health Board has made further steps forward which are clearly starting to change the nature and tone of the relationship between the people who use the service and those who are currently delivering it. That is still being reflected in consistently high levels of positive feedback from PALS surveys and feedback from external sources.

The initial engagement programme has now been completed with the successful delivery of a third engagement event in Bridgend and there are clear plans emerging for the next twelve months. In the meantime, those who are leading the programme have visibly grown in confidence and capability and are increasingly setting the agenda going forward.

That was particularly evident in the communication forums which were organised by the Panel for women and families around the publication of the Winter 2019 Quarterly Progress Report. The events were well managed, sensitively handled and the care and compassion which was shown by the Health Board staff at all levels was very much appreciated by those who attended.

There is still much to do, particularly to ensure that the learning from engagement is reflected in service design and delivery and there are still residual issues around the management of historical complaints, concerns and feedback. The Health Board and the Panel must also find an effective way of measuring the impact of its engagement work.

However, the maternity service is in a fundamentally different place than it was a year ago in the way that it engages and communicates with women, families and the wider community. This has been demonstrated quite clearly in recent weeks by the way in which the maternity services team has reacted to the current COVID-19 situation with the provision of clear, timely and compassionate messaging for women and families who might be concerned.

It was also self-evident in the response of mothers and families to the formal opening of the Tirion Birth Centre at the Royal Glamorgan Hospital on 9 March 2020. In every improvement journey there are symbolic events which demonstrate that a corner has been turned; they cannot be quantified or turned into a performance metric but they do provide a real sense that things are changing for the better. This was one of those events.

Not only are the state-of-the-art facilities at the Royal Glamorgan Hospital purpose designed around the needs of women, their partners and families, the strong bonds which have been built between the staff and service users are self-evident. That is in stark contrast to the situation which was reported by the Royal Colleges just over 12 months ago.

Since its creation in March 2019, the Tirion Birth Centre has become a hub for women, babies and families and a significant number turned out to join the staff in celebrating its early success. Some spoke passionately about the way they had been cared for by staff and there was a palpable sense of pride and shared ownership which was incredibly heart-warming for those members of the Panel who had the privilege of attending.

The Panel acknowledges that in relative terms, Tirion is currently a small but nonetheless important part of overall service provision; however, it is seeing evidence of a similar shift in attitudes and relationships in maternity service settings right across the Health Board area.

A more detailed summary of the key developments which have taken place during the period under review is set out in the following paragraphs, together with an assessment of what further remains to be done in terms of engagement and communication.

5.1 Strategic Planning, Design and Delivery

The Women and Families Engagement Project Group continues to lead the approach to maternity services engagement and communications activities with women and families. The group has a strong and innovative chair in the form of a Consultant Midwife who also leads the Quality of Women's and Families Experience workstream.

The Group has consistent multidisciplinary membership which includes women and families' representatives, highly committed obstetricians and midwives as well as patient and public engagement leads.

This collaborative approach to engagement continues to pay dividends and this has been a driving factor in the development and incremental refinement of the three community engagement events which lie at the heart of the Health Board's approach.

5.2 Community Engagement Events

Following on from those held in Merthyr Tydfil and Llantrisant in November 2019, the third community engagement event was held in Bridgend on 25 February 2020. The event had a particularly positive and relaxed atmosphere due in part to the setting in the local leisure centre. In addition to those who attended by design, women and families who were visiting the leisure centre for other purposes also joined in the café conversations.

The mix of staff and organisations working in partnership on the day reflected the multidisciplinary nature of the event; those attending were able to talk informally with consultant obstetricians, midwives and senior leaders from the Maternity Improvement Programme. The patient and public engagement team were also present together with representatives from Sands, the Community Health Council and the Health Board's Chaplaincy.

The cascading of experience in face-to-face communication has been a significant feature of the success of the maternity services engagement programme and is now being used more widely by the Health Board in a range of health and care settings.

In addition, banners, posters and other visual aids have been developed to show how the Health Board is making progress against the Royal Colleges' recommendations. Social media and other publicity materials have been used well, resulting in stronger interest and increasing participation.

A range of engagement methods for capturing insight, experience and thoughts on participation in the events have also been built and this will be invaluable for future engagement events and the identification and measurement of effective practice.

In short, this is a very different maternity service than the one which the Panel first encountered 12 months ago. It is now confident in engaging with the women and families who use the service and has a range of tools and skills to enable that to happen; this can only pay further dividends for the service going forward.

The feedback from the three development events has improved as the events have evolved and matured and the most recent event in Bridgend elicited the most positive feedback yet.

As in other events, an engaging visual mapping technique was used to produce a vibrant thematic representation of the priorities and messages heard from women and families attending. The technique acts as a prompt for conversation and sharing experience.

Reflections from one of the women who participated demonstrates the importance of the in-depth discussions, opportunities to share experiences and importantly, the confirmation that women and families felt valued and listened to by the Health Board team. This reflects a considerable transition from the experiences of those families who shared their concerns during the Royal Colleges' review.

> *"I just wanted to thank you (all) for your time and for actually making my thoughts, feelings and opinions feel valued and listened to. It really helped me and lifted my mood. It's the best thing I've done so far in 2020, coming to the session today. Thank you again."*

5.3 USING THE PRODUCTS OF ENGAGEMENT

The visual minutes produced during the engagement events are now being displayed in the Health Board's three maternity units together with an action log which highlights the improvements which have already been made in response to the feedback provided.

The visual minutes provide a rich-picture narrative of the Health Board's improvement against some of the key issues that were highlighted by women and families engaged during the Royal Colleges' review, including poor communication, a failure to listen and a lack of focus on women's experiences. The diagram below is a copy of the visual map from the second event in Llantrisant.

Figure 3: *Visual Minutes – Llantrisant Community Engagement Event*

The Health Board recognises that holding engagement events is merely the first step in the process of co-production. There is little point in listening to women and families if what they say does not then result in changes in the way that the service is provided. For that reason, a detailed thematic analysis of the feedback which was received from the first two engagement events has been undertaken and the analysis of the third event is in progress.

The Panel looks forward to receiving the full thematic report together with the engagement strategy and action plan which emerges from that report.

It is important that the 2019/20 Engagement Summary Report is fed back to those women who have contributed and to the wider communities to demonstrate the way that their contributions have influenced change and improvement. The Panel will be looking for evidence of how that has been achieved.

NEXT STEPS - Action 1: The Panel awaits the publication of the thematic analysis of the outcome of the three engagement events held during 2019/20 together with the detailed action plans which emerge from it.

The Panel is encouraged to see that the learning from maternity services is increasingly influencing the Health Board's approach at an organisation level. A corporate engagement and communication strategy has been drafted and this will be shared with the Panel by the end of March. It has been significantly influenced by the maternity engagement approach.

5.4 MEASURING SUCCESS

In the Winter 2019 Quarterly Progress Report, the Panel highlighted continuing concerns about a lack of capacity and capability to develop a patient and public engagement strategy and systems across the organisation. The Panel is pleased to acknowledge that in the last three months, the organisation has allocated additional capacity in this area and enhanced the skills of existing maternity staff, resulting in sustained progress. However, the delay in appointing a strategic lead at a corporate level is a matter of concern.

Building on the lessons learned from the community engagement events, the Quality of Women's and Families Experience Project Group is now developing other mechanisms for capturing and responding to women's stories and is outlining achievements in regular reports to the Panel.

This includes the following development which are either in the process of being delivered or planned for delivery within the next reporting period:-

- The Patient Advice and Liaison Service (PALS) real time feedback initiative is being rolled out to capture women's experiences at the antenatal stage. This will enable the Health Board to identify and resolve issues or concerns at source and allay emerging fears about giving birth. The analysis of emerging themes, together with the issues consistently raised in complaints and concerns will inform the 'My Maternity, My Way' agenda and provide evidence for action and improvement;

- Leaflets and other promotional material for 'My Maternity, My Way' have been designed and increased support is being planned. Networking with women and families has continued and additional membership is being encouraged;

- Discussions are taking place around the way that those families who have been part of the Panel's co-production approach to improve engagement and communication can work with the Health Board on issues such as coordinated bereavement support and effective complaints and concerns handling;

- Women's stories have been shared with clinicians at the last three Governance Days, resulting in improvement actions being allocated to relevant forums;

- A Task and Finish Group began work in March, based on co-production principles, to explore one of the key issues emerging from engagement events (the involvement of partners during labour and the provision of dedicated family space for families);

- In addition, members of the team are receiving training in Experienced Based Co-Design in order to work with family members on the design and delivery of empathetic and effective complaints and concerns handling.

The procurement of a widely used and standardised tool for gaining meaningful and organised feedback on experience of maternity care remains a priority. The work which the Welsh Government and academic partners are developing around Patient Reported Outcomes Measures (PROMS) and Patient Reported Experience Measures (PREMS) is of significant interest and both the Heath Board and the Panel are monitoring this development closely.

NEXT STEPS - Action 2: The Panel looks forward to the publication of the Maternity Services Engagement Plan for 2020/21 and in particular, to the launch of the feedback monitoring tool which is currently being developed.

5.5 Complaints, Concerns and Support for Families

During engagement and communication events and through direct contact with the Panel, women and families continue to express dissatisfaction with the response they have received to complaints, concerns and long-term investigations. The current arrangements are not always well coordinated and promises and deadlines are not always kept.

In its last report, the Panel said that the Health Board had developed a plan to address these issues at organisational level and that additional capacity had been identified to manage the backlog of historical complaints within maternity services. The Panel believed that it was an appropriate response to the issue and committed to focus on how it was being delivered in subsequent quarterly reports.

Over the last three months, progress has undoubtedly been made in terms of responding within more appropriate timescales to new referrals. Restructuring work has also been taking place so that in appropriate cases, staff are enabled to respond to concerns at a directorate level rather than awaiting corporate approval which builds in delay. However, there are still significant challenges in terms of addressing the backlog of historical complaints and the Panel has asked the senior leadership team to review the way that the plan is addressing the consistency, coordination and timeliness of responses.

Despite the progress which has been made, the Panel feels it necessary to emphasise, once again, that the Complaints and Concerns Improvement Plan must be delivered quickly and effectively if it is going to regain the trust and confidence of the women and families who have been affected by their past experiences.

Although it is not within the Panel's direct terms of reference, it is a barrier to progress and the Panel will continue to monitor progress against the corporate plan and the application of the plan at the maternity services level. The Panel has also encouraged the Health Board to include specific performance metrics within the IPAAF to ensure that outcomes can be monitored on a regular basis.

NEXT STEPS - Action 3: Once approved, the Panel will expect the Complaints and Concerns Improvement Plan to be a regular feature of the Health Board's performance reporting and will expect to see relevant performance metrics included within the next phase of development of the IPAAF.

5.6 Co-production With Women and Families

At the end of 2019, the Panel heard from women and families who had attended its regular updates that the format for information sharing and the opportunities this provided for the Panel to hear their experiences was not meeting the needs of all those involved.

As a result, the Panel established its own Engagement Task and Finish Group to explore how best to engage and communicate with women and families about the Panel's work. Since then, the group has evolved significantly and has become a genuine co-production forum where the women and families come together in an equal partnership with the Panel, the Health Board and Welsh Government colleagues in building a range of communication methods that meet different needs and expectations.

Their ideas and powerfully expressed views are not only contributing significantly to the style and shape of the Panel's communication and engagement processes, but are also having a major influence on the Health Board's work and their understanding of the needs of those involved. For example:-

- women and families told us that the Panel's briefing was too formal and that they wanted 'drop in' sessions at different times and venues so that more people could attend;

- there should be opportunities for women and families to move around the room to different areas with clear information about what was available and who they could speak to;

- they emphasised that women and families had different needs and were at various stages in their journey following experiences of pregnancy and birth;

- they suggested that there should be opportunities for one to one conversation and that there should be triage as women and families arrive to ensure that they were supported to speak with the *"right person about the right thing"*;

- they wanted information about complex issues such as the clinical review process and the self-referral process to be clear, in non-technical language and wherever possible, visually presented;

- they wanted clear visuals from the Health Board on improvement and change in maternity services as well clear information to show what was being done to address issues raised by the Royal Colleges' review such as bereavement support, complaints handling and engagement.

All of their suggestions have been put into practice and in February a meeting was held to evaluate the revised format following the sessions with women and families in Merthyr and Llantrisant.

One of the women and family representatives reflected that the visual maps, poster banners, visual guides and pathways were *"a hundred times better"*, that the atmosphere was *"welcoming, calmer and relaxed"* and that women and families were able to *"make the right contact – who was best to deal with it"* and found it *"easy to mention something"*.

The women and family representatives had spoken with others attending and informal feedback supported the view that the revised format was more effective.

They *"felt listened to"* and reflected that it was important that the Minister was part of the session and joined families in conversations. They felt that he had heard and understood their experiences and views, particularly when he spoke during a session in the National Assembly for Wales and things that they had said *"were filtered back".*

The women and family representatives have also been highly influential in shaping how they want their stories to have an impact on the clinical review process and also in the way that they want to be supported independently. In due course, there will be a need to evaluate how this has worked for the wider group who have been involved in the clinical review process and supported to tell their stories.

The women and family representatives have also been clear about their needs for support from independent organisations such as SANDS together with the bereavement services and counselling involvement at the sessions. In addition, they have strong ideas on the way that they can bring their experience of bereavement to the reshaping and coordination of the range of support and services for those who have experienced loss, particularly in the early stages of bereavement.

The Health Board hopes to work with women and families to review those different models of coordinated support and look at their suggestion for the development of Family Liaison roles for newly bereaved families.

The continuation of the co-production approach is important and the women and families have suggested that they could make contact with others involved by sharing their personal experience of being part of the Panel's update sessions in an interview for a 'women and families' newsletter'. They want to reflect on *"how much it means to be heard – not just listening but understanding"* and *"how the Panel is doing things differently as a result of our views".*

As a result of the feedback from the women and family representatives on the Task and Finish Group, the Panel's future sessions with women and families will be described as a 'Forum' that provides *"a chance to speak"* as well as having the opportunity to hear.

As the COVID-19 situation develops, there is an increased need for information and it is more important than ever that the voices of women and families are heard. Innovative forms of communication, including web-based options, are being explored with those women and families involved.

5.7 STAFF ENGAGEMENT

During January and February, the Panel continued to include engagement with staff as part of its monthly assurance visits to maternity units across the Health Board area. However, it proved difficult to get staff together in large numbers due to operational commitments. As such, the level of engagement has not been as significant as the Panel had hoped.

This has required the Panel to explore a range of new approaches to engage in meaningful discussions with staff at all levels, from medical, midwifery and other backgrounds and across all three of the hospital sites.

The intention was that rather than ask staff to come to the Panel's meetings, the Panel would join staff at regular forums including Governance Days and clinical meetings. However, that is clearly not going to be an option in the short term given the COVID-19 situation. As an alternative, the Panel is urgently exploring potential technological solutions including the use of video-conferencing, webinars and live-blogging.

It is particularly important that the Panel has an effective means of triangulating the evidence it gathers from other sources with the views and opinions of staff. At this stage that has not happened to the extent which is necessary and in so far as the current situation allows, this will be a specific focus for the Panel in the coming months.

6 ASSURANCE FRAMEWORK AND MATURITY MATRIX

In its Autumn 2019 Quarterly Progress Report, the Panel set out its intention to utilise an evidence based, Integrated Performance Assessment and Assurance Framework (IPAAF) as the basis for its future reporting to the Minister.

The IPAAF framework is outlined in schematic form at *'Appendix E'* and a more detailed explanation of the framework can be found in Section 6 of the Autumn 2019 report. It is not the Panel's intention to repeat that information here, other than briefly.

Both the Panel and the Health Board are fully committed to the IPAAF model. The IPAAF is an important element of the oversight process because it will enable performance improvement to be monitored, assessed and reported objectively against a maturity matrix, based on evidence and outcomes. Indeed, the Health Board has adopted a similar approach to performance monitoring and assessment for its wider Corporate Development Plan.

The IPAAF will also, in the longer term, provide the means by which the Health Board will be able to gain the assurance it needs that the maternity and neonatal services it provides are safe and effective, well managed and well lead and focused on the experience of the women and families they care for. As such, it is a good investment in time and energy and will, if fully developed, create a legacy which extends beyond the oversight process.

6.1 DEVELOPMENTS DURING THE CURRENT REPORTING PERIOD

When the Panel last reported in January 2020, it expressed some frustration with the pace with which the IPAAF was being developed.

In January, additional resources were brought into the Maternity Improvement Team and there were changes in structure which provided increased capacity and greater focus in key areas. As a result, the Maternity Improvement Director has been able to focus more time and energy on developmental issues and to her credit, a significant amount of work has been completed in a relatively short period of time. This culminated in a workshop being held on 09 March 2020 where broad agreement was reached about:-

- the performance metrics which will be used to populate the three constituent performance domains of the IPAAF;
- the methodology which will be used to make reasoned assessments against the various levels within the Maturity Matrix;
- how the IPAAF should be developed further going forward and in particular what additional metrics would need to be developed.

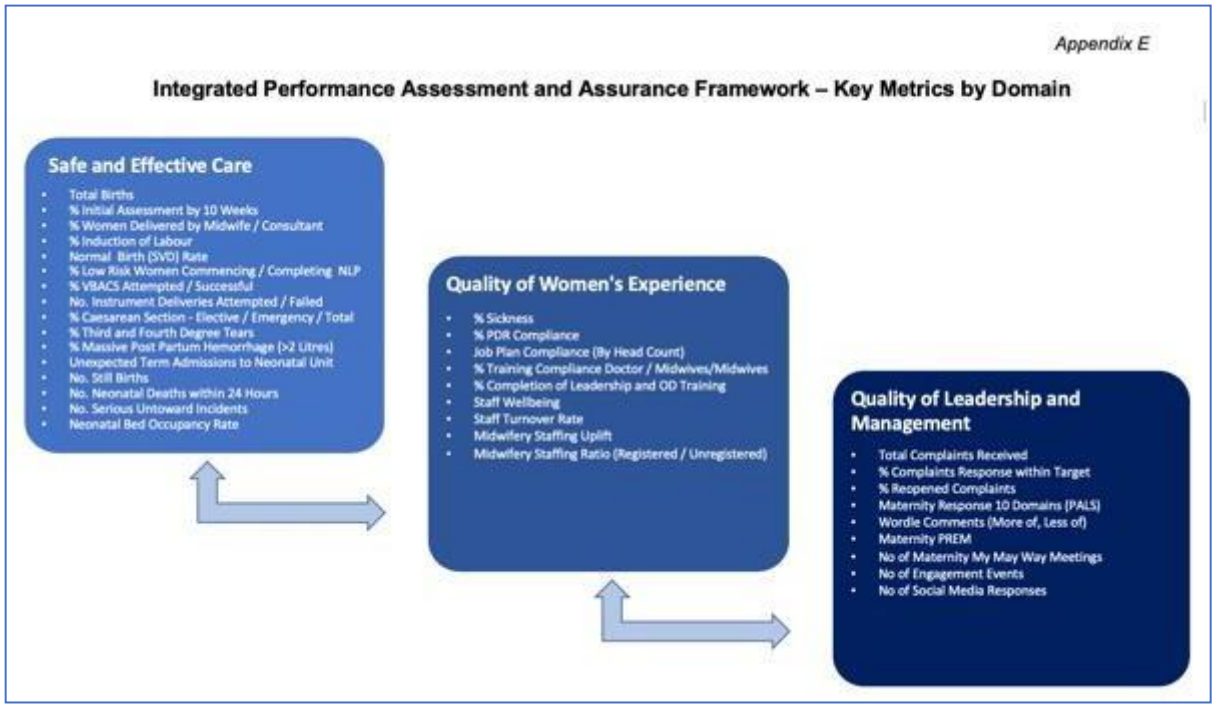
The workshop was attended by representatives of the All-Wales Maternity and Neonatal Network which is developing the performance framework which will form part of the All-Wales Maternity Vision.

This will help to ensure consistency of approach and ultimately ensure that the Health Board's performance can be compared like for like with other Health Boards in Wales when and where appropriate.

Although the IPAAF will still require further refinement and incremental adjustment over the coming months, this represents good progress and the Panel is satisfied that a workable performance assessment and assurance framework is now in place.

A summary of the performance metrics which have been agreed in each of the three performance domains is set out below. A larger version of the document is included at *'Appendix F'* for easier reference.

Figure 4: *IPAAF Performance Metrics by Domain*



Performance information dating back to April 2019 has been collated and run charts are being produced. This is supporting the Health Board's performance management frameworks alongside the weekly performance monitoring process which is managed by the Welsh Government and attended by the Panel's Business Manager.

6.2 Establishing Performance Thresholds and Targets

The prioritised performance information that the Health Board is capturing is increasingly being used to monitor trends over time and will enable the further refinement of performance thresholds or targets where those add value.

However, at this stage, the Health Board has resisted the temptation to set targets until further analysis has been undertaken to understand the desired outcome to be achieved and what represents a meaningful measure of improvement.

That is particularly important in areas such as smoking cessation and induction of labour, where tangible improvements could take years rather than months to deliver.

The Panel supports this approach. There is a danger that setting arbitrary targets without fully understanding the intended outcomes could be counter-productive and result in perverse behaviours which compromise rather than improve safety and detract from the experience of women and families rather than enhance it.

As an initial step, the Health Board has analysed information produced at national level through the MMBRACE and NMPA national surveillance surveys and identified those areas where the Health Board's outcomes appear to be outside the expected range. Setting upper and lower limits on expected performance over time will encourage a systematic approach to continuous improvement. It will also help to understand and reduce unwarranted variation and improve the safety and effectiveness of care.

There are some challenges in this because the national surveillance datasets are historical and the information may now be as much as four years old. Analysis is also complicated by the fact that the service has been reconfigured since the data was gathered.

Despite their limitations in the current environment, the national data sets can be viewed in the context of information from other sources (quantitative, qualitative and informal). On that basis, the Health Board has identified a number of areas where further analysis is needed to determine whether there is a need for improvement in the current environment and if so, whether performance thresholds or targets might be helpful in achieving that improvement. The areas which are currently being investigated include, for example:-

- rates for induction of labour;
- rates for caesarean section;
- instrumental birth;
- obstetric haemorrhage;
- unplanned maternal re-admission over 42 days.

Two multidisciplinary Task and Finish groups have been established to progress this while other work is being conducted by specialist groups within the clinical governance framework. It is anticipated that further information about this can be provided in the Panel's next progress report subject, of course, to the impact of the COVID-19 response.

6.3 APPLYING THE IPAAF

Over the last three months, the Maturity Matrix which supports the IPAAF has also been further developed in conjunction with the development of the Health Board's corporate performance framework, which also utilises the Maturity Matrix model as the basis for performance assessment and reporting.

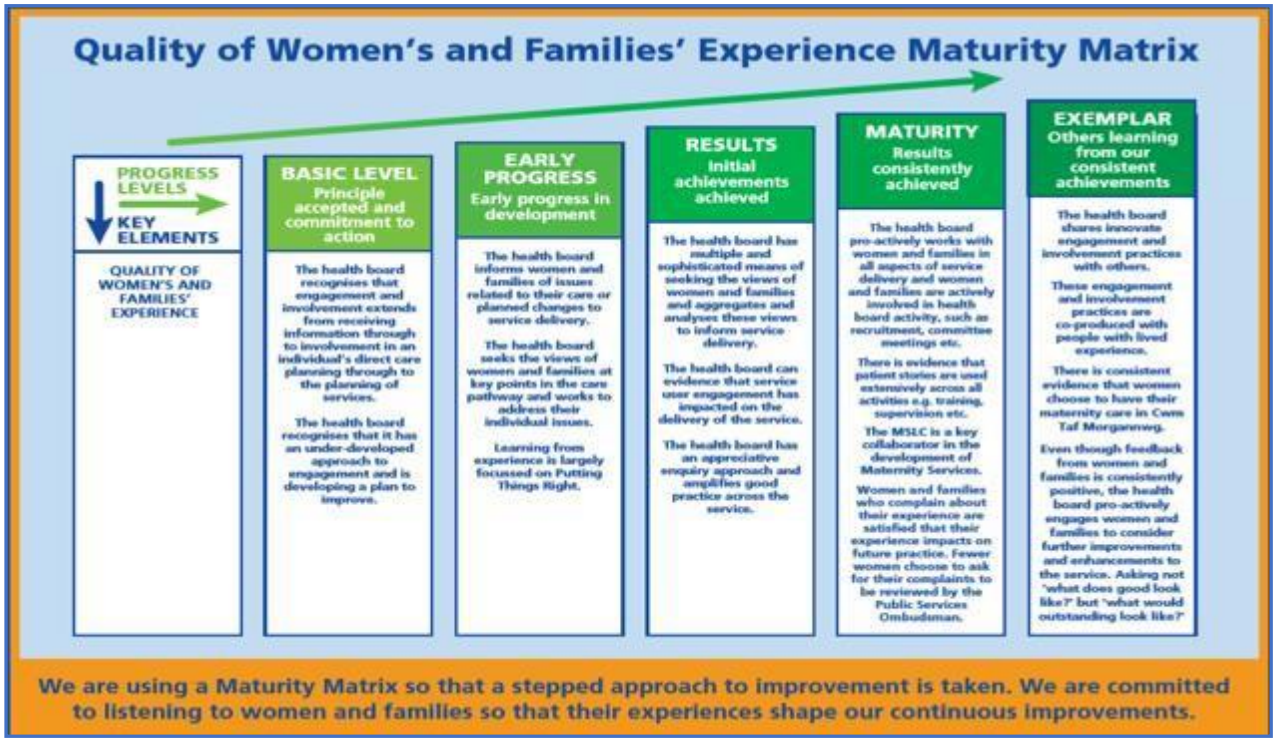
The current iteration of the Maternity Improvement Maturity Matrix is attached at *'Appendix G'*.

The Maturity Matrix describes five levels of progress using a series of narrative descriptors, as follows:-

- **Basic** (Principles accepted and commitment to action);
- **Early Progress** (Evidence of early progress and developments);
- **Results (**Initial milestones and results achieved);
- **Maturity** (Results consistently achieved);
- **Exemplar** (Others learning from our achievements).

Separate descriptors have been developed for each of the three IPAAF performance domains (Safe and Effective Care, Quality of Women and Families' Experience and Quality of Leadership and Management). The Maturity for the Quality of Women and Families' Experience domain is shown below by way of example.

Figure 5: *Example of Maturity Matrix*



One important development which has occurred in the past three months is the Health Board has now documented the IPAAF process and outlined the assessment methodology which will provide the basis for assessing levels of progress.

The Health Board is referring to this methodology as an ‘assessment framework’. In other assessment models this is sometimes referred to as a ‘judgement framework’. The two things are essentially the same; it is the process by which a range of information from multiple sources is ‘triangulated’ to provide a comprehensive understanding of performance and improvement over time.

Rather than simply relying on traditional quantitative measures, the assessment tool which underpins the framework is designed to capture a ‘rich picture’ of an organisation’s performance based on the interplay between four aspects, namely:-

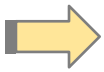
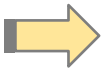
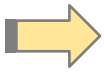
- Measures (the qualitative and quantitative performance metrics in the IPAAF);
- Proactive Internal Review (such as clinical audits or quality improvement activity);
- Feedback (from both formal and informal sources);
- Progress (in this case, delivery against the Maternity Improvement Programme).

The intention is that as the maternity service governance frameworks further mature and become aligned with the Health Board’s performance framework, the work of the Maternity Improvement Programme will transition from a dedicated team to the maternity service. Management reporting will progressively be via usual Health Board business processes rather than to a dedicated Maternity Improvement Board as sustainable change and improvement becomes embedded in normal operational practice.

6.4 Current Assessment Against the Maturity Matrix

The significance of the development work which has been undertaken over the last three months is that for the first time, the Health Board has now been able to formally self-assess against the Maturity Matrix and has concluded that the current position in each of the three domains is as follows:-

Figure 6: *Maturity Assessment – 31 March 2020*

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

The Panel has reviewed the Health Board's rationale for that assessment and agrees fully with the conclusions which have been reached, i.e. that the Health Board is now making 'Early Progress' and moving towards the 'Results' phase in each of the three performance domains.

6.5 Development of the IPAAF – Next Steps

Given the progress which has been made during January, February and March 2020, the Panel believes that the IPAAF now provides the early basis of a workable performance assessment and assurance framework which enables an objective, evidence-based assessment of progress over time to be provided to the Minister.

However, further development work is required to ensure that the framework is as meaningful and reliable as it can possibly be.

Those areas for further development have been identified at various points in the preceding paragraphs and rather than restate them, they are captured in the next steps action below.

The Panel will work with the Health Board to further these developments, subject of course to the obvious constraints which exist in the current operating environment.

NEXT STEPS – Action 4: Further development work is required to consolidate the progress which has been made in developing metrics for the IPAAF, particularly in terms of (i) identifying performance thresholds or targets where appropriate, (ii) supplementing areas where the metrics are limited (especially Quality of Women and Families' Experience) and (iii) ensuring continued alignment with the emerging all-Wales performance framework.

One additional area where particular attention needs to be paid is in terms of the development of the assessment methodology which supports the Maturity Matrix.

At this stage, the Health Board has assessed itself as making 'Early Progress' in each of the three performance domains and on the basis of the information provided in this report, that is largely self-evident. As such, it was not difficult for the Panel to objectively verify the Health Board's self-assessment.

What is also evident is that in all three performance domains, but particularly in the Safe and Effective Care and Quality of Leadership and Management domains, there is a steady progression towards the 'Results' phase. However, making the judgement that the criteria have been met which justify that assessment will require more careful analysis. It will be very difficult to determine whether the Health Board is delivering results or whether it has achieved its initial milestones, if it is not clear from the outset what results and milestones are intended.

The descriptors in the matrix are helpful but to be truly meaningful, they will need a strong link back to the performance metrics within the IPAAF and the milestones and deliverables within the Maternity Improvement Plan. That will apply equally, if not more so, to the 'Maturity' and 'Exemplar' levels within the matrix.

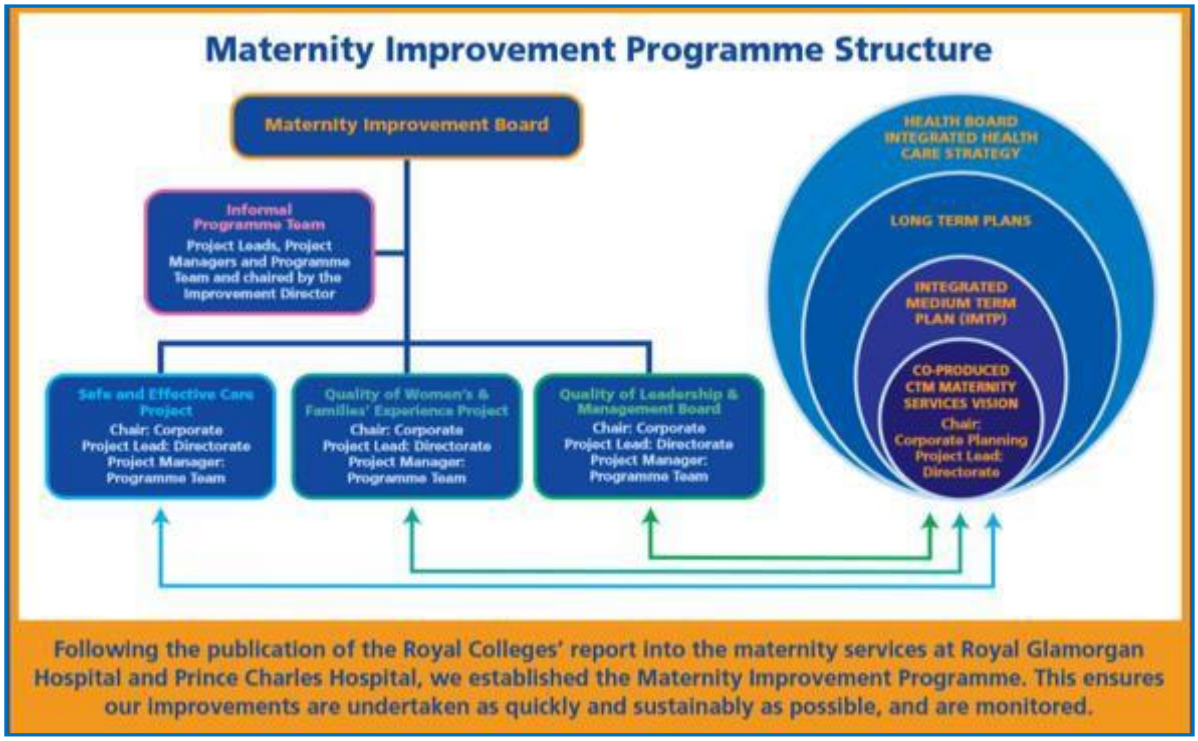
In anticipation that in the near future, a decision will need to be made about progression across the Maturity Matrix from 'Early Progress' to 'Results', the Panel has asked the Health Board to identify which key indicators (including quantitative and qualitative performance metrics, situational factors and formal and informal feedback) and which of the MIP deliverables will be used (i) to make that assessment and (ii) to provide the requisite assurance that the assessment is valid.

NEXT STEPS - Action 5: Further development work is required to identify outcome-based measures which will enable an objective assessment to be made about what, in each of the performance domains, constitutes achievement of the 'Results', 'Maturity' and 'Exemplar' elements of the Maturity Matrix.

7 HEALTH BOARD RESPONSE

The Health Board's response to the Royal Colleges' review has been explored in some detail in the Panel's previous reports and is not repeated here. However, as a brief reminder, the diagram below explains the framework which has been put in place to manage the improvement process.

Figure 7: *Maternity Improvement Programme Structure*



7.1 DEVELOPMENTS IN THE CURRENT REPORTING PERIOD

Over the past three months, the Health Board has continued to work constructively with the Panel to drive forward the Maternity Improvement Programme (MIP).

Despite all of the other challenges which the organisation faces at this time, there remains a genuine sense of ownership and commitment at Chair, Chief Executive (CEO) and Board level. The SRO continues to work constructively with the Panel within a mutually supportive but challenging atmosphere.

The improvement framework which has been put in place through the Maternity Improvement Board (MIB), the Maternity Improvement Team (MIT) and the three Project Boards continues to evolve and by and large, it continues to work increasingly well.

There were capacity issues in the MIT in the run up to Christmas 2019 and this was affecting the pace of progress. However, those issues were addressed quickly and positively by the Health Board through a restructuring of the MIT and by bringing in additional capacity, particularly in support of the Clinical Review Programme and the redaction process which supports it.

Since the end of January, the MIT has been working at close to full establishment which has noticeably improved pace and administrative efficiency and freed up the capacity of the Maternity Improvement Director (MID) to focus on developmental issues. This has enabled a number of important pieces of work to be progressed during the quarter, not least:-

- the agreement and sign off of the self-referral process;
- the redevelopment of the women and families database on the Datix system;
- further development of the IPAAF;
- a refresh of the Maternity improvement Plan;
- the more timely and accurate presentation of evidence to the Panel;
- the delivery of another sizeable tranche of the MIP actions.

Whilst that increased capacity and capability was welcomed, it was, unfortunately, short-lived. The SRO has recently advised the Panel that the Maternity Improvement Director has secured a new post in the Health Board and is moving on imminently to support the COVID-19 response. At the same time, there have also been other enforced changes within the MIT which will result in a short-term loss of knowledge and experience which may be difficult to replace, particularly when the organisation is, quite rightly, having to divert resources into the response to deal with the impact of COVID-19.

The SRO has made a commitment to the Panel that he will do what is reasonably possible to ensure that staffing levels within the Maternity Improvement Team are protected for as long as possible, particularly those involved in supporting the Clinical Review Programme. In the meantime, proposals to address the imminent departure of the MID and mitigate the impact of other changes in the MIT are currently being developed by the SRO.

NEXT STEPS - Action 6: The Panel looks forward to receiving the SRO's proposals for replacing the Maternity Improvement Director when she moves on to her new role.

The newly appointed Director of Midwifery took up her post in early January. This is the first time that the senior midwifery post has been offered at Director level and the benefits of that are already becoming apparent. The Director brings with her a wealth of experience and relevant insight which is already resulting in increased momentum, new ideas and a more strategic approach.

The appointment also means that the triumvirate of medical, clinical and managerial leadership is now in place on a substantive basis for the first time since the improvement programme commenced. It is noticeable that the leadership team is now behaving in a more cohesive way and is starting to take control of the improvement agenda with the MIT increasingly taking on a supporting role. That greater ownership and in particular the increasing involvement of the Clinical Director is welcomed.

In recent weeks, the Panel has become increasingly aware that it has not paid as much attention to the neonatal service as it has the maternity service aspect of the improvement process.

An invitation has been extended to the Health Board's Consultant Neonatologist to attend the next formal Panel meeting to provide an overview of the neonatal service and this will now become an area of focus in the next reporting period, subject to the impact of the COVID-19 situation.

NEXT STEPS – Action 7: During the next reporting period, the Panel will pay increased attention to the neonatal service and as a first step, will invite the Consultant Neonatologist to attend the next Panel meeting to provide an overview of the service.

7.2 Progress Against the 'Next Steps'

In Section 9 of its previous report, the Panel identified a number of areas where it expected to see the Health Board make progress during January, February and March 2020.

These 'Next Steps' actions are set out in the table below together with a brief assessment of the current position against each.

Figure 8: *Summary of Progress against 'Next Steps' Actions as at 31 March 2020*

Agreed Next Steps	Summary of Progress as at 31 March 2020
1. **Engagement with Women and Families** - Complete the planned community engagement events with women and families, assess the outcomes and develop a plan to reflect the lessons learned in operational delivery. **(Actions 1,2 and 3)**	**GOOD PROGRESS**. The first phase of the engagement programme has now been completed. Further work remains to be done, particularly to ensure that the feedback from the three community events is evaluated and reflected in service delivery. That work is in progress and a delivery schedule will be published in early April. This also includes a new engagement and communication plan for 2020/21. A more detailed summary is included in Section 4.1.

Agreed Next Steps	Summary of Progress as at 31 March 2020
2. **Complaints and Concerns** - Monitor implementation of the Complaints and Concerns Improvement Plan and incorporate appropriate metrics into the IPAAF. **(Action 4)**	**SOME PROGRESS.** Progress has been made against the complaints and concerns action plan, particularly in terms of the timeliness of the response to new complaints and concerns. However, problems still remain in the terms of quality, particularly relating to historical complaints. A number of relevant performance metrics have been incorporated into the IPAAF. Further detail is included in Section 7.3.
3. **Clinical Review** - Progress the clinical review process to implementation stage with a specific focus on supporting women and families involved. **(Actions 5 and 6)**	**GOOD PROGRESS.** Six clinical review teams are now operating and work has commenced on the second tranche of reviews. A quality assurance process has been developed. Arrangements are in place, including CHC advocacy, to involve and support women and families through the process if they wish to be involved. A summary of the progress which has been made in the last quarter is included in Section 5.
4. **Development of IPAAF** - Further develop the IPAAF with more sophisticated metrics, clearer priorities and stretching but achievable improvement targets over time. **(Action 7)**	**SOME PROGRESS**. A workshop was held in March where a suite of metrics was agreed, aligned to the national performance framework. This will require further development over time, particularly in relation to the Quality of Women and Families' Experience domain. At this stage, targets have not been set pending further analysis through a number of Task and Finish groups to identify what would be appropriate. Further details are set out in Section 6 of the report.
5. **MIT Capacity** - Ensure that by the end of January 2020, all of the resources required to support the MIP are in place and that the MIT is restructured and supplemented to provide greater capacity and increased resilience. **(Action 8)**	**COMPLETED.** Since the end of January, the MIT has been working at full establishment which has improved pace and administrative efficiency and freed up the capacity of the MID to focus on developmental issues. New skills and capacity have been added to good effect, particularly in support of the clinical review process. Further information can be found in Section 7 of the report.

Agreed Next Steps	Summary of Progress as at 31 March 2020
6. **Joint HIW/WAO Review** - Ensure that the action plan developed in response to the joint HIW/WAO Review of Quality Governance Arrangements is aligned with the MIP. **(Action 9)**	**COMPLETED.** A link has been developed with the lead for the corporate development work who is leading on the action plan which the Health Board developed in response to the HIW/WAO recommendations. The two plans have been reviewed and there is read-across. There is also alignment in the way in which the two improvement plans are been delivered and the corporate approach draws heavily on the approach which has been adopted in maternity services improvement, including the use of an IPAAF and maturity matrix). Further information can be found in Sections 6 and 7.
7. **Further delivery against the MIP** - and a focus on embedding those recommendations which have already been delivered into operational practice. **(Action 10)**	**GOOD PROGRESS.** A further 16 MIP actions were signed off as completed during the quarter and 5 others were re-verified following a further review of evidence to ensure that they remain embedded. That brings the total now completed to 41 which is 52% of the total. Further information can be found in Section 8 of the report.
8. **MIP Development** - Develop the MIP into a more dynamic and constantly evolving document with clearer actions and milestones for delivery. **(Action 11)**	**SOME PROGRESS.** The MIP has been enhanced to include more defined milestones and timescales and a high-level timeline is now available. However, further work will be required in the next period to review and consolidate the outstanding recommendations and to make the plan more responsive to new and emerging issues. Further details are set out in Section 8 of the report.

7.3 WIDER HEALTH BOARD DEVELOPMENT PLAN

At an early stage in the improvement process, the Health Board recognised that the underlying causes of the failings which were identified by the Royal Colleges were unlikely to be confined to maternity services.

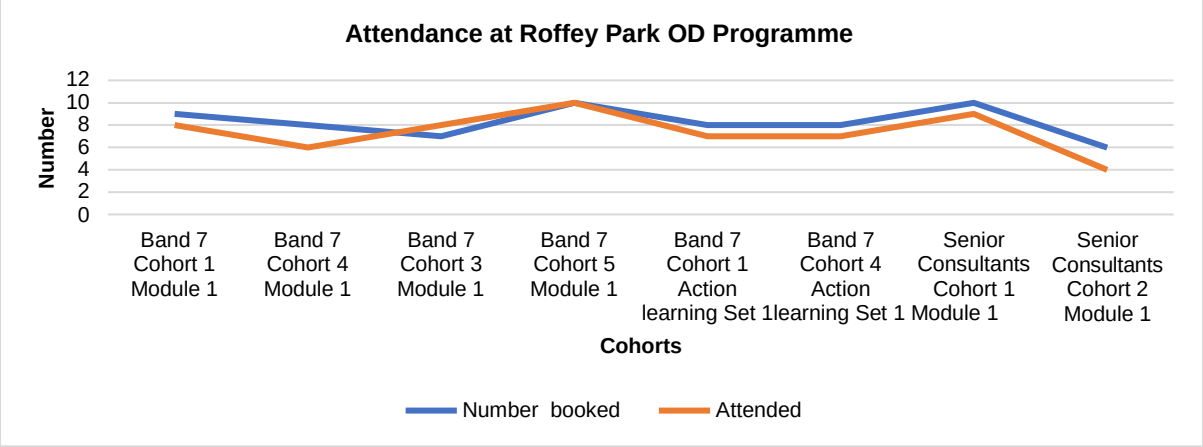
As a result, the Health Board designed and is now delivering a wider organisational development programme. Amongst other issues, this includes a programme designed to improve leadership and governance at all levels that will redefine the culture and values of the organisation. This programme of work is both informed by and complementary to the maternity services improvement work which the Panel oversees.

The Panel continues to work closely with the CEO to ensure that there is synergy between what is happening in maternity services and the wider corporate improvement plan. In recent weeks, in addition to the roll out of the new operating model, a new corporate performance management framework has been published and the organisations wider engagement and communication strategy is nearing completion. All of these things will help ensure that the improvements which are being delivered in maternity services are sustainable in the longer term.

In respect of maternity services in particular, two development programmes are currently being been rolled out. The first is a leadership programme for Consultants and the Senior Midwifery Leadership Team which was launched on 14 November 2019. The second, also launched in mid-November, is a culture and values programme aimed at all three hundred or so maternity services staff. This will focus on the development of a growth mind-set, compassion, collaboration and emotional intelligence.

Both of these programmes are important developments and their success will be key in addressing some of the underlying cultural issues which run through a significant number of the Royal Colleges' recommendations. As such, the Panel is monitoring the roll out of the programme. It will be seen from the charts below that attendance has been good and staff feedback has been positive.

Figure 9*: Numbers attending Leadership Development Programme*



Clearly, the Health Board's response to the COVID-19 outbreak will impact on the delivery of the programme given that all non-essential training has been suspended for the foreseeable future. However, the programme has begun in earnest and to this point has been well received by staff and it will be picked up again once the current situation is resolved.

There has been some progress against the corporate complaints and concerns action plan with a revised structure, additional resources and a new complaints and concerns policy which places a greater onus on local ownership. There are signs of better performance, particularly in terms of improvements in timeliness for new complaints and a reduction in the number of complaints which are reopened.

However, recent feedback from women and families suggests that resolving longstanding historical complaints remains a problem and the Panel will continue to focus its attention on this issue during the forthcoming period.

There are challenges around the quality of responses being provided and it is encouraging to learn that the new Director of Midwifery is taking personal ownership of that in so far as maternity services are concerned. However, in the short term, the need to provide the right response rather than a timely response is continuing to mean that some responses fall outside the timeliness criteria.

8 ASSESSMENT OF PROGRESS AGAINST MATERNITY IMPROVEMENT PLAN

The Health Board's Maternity Improvement Plan (MIP) contains 79 actions, 70 of those derive directly from the Royal Colleges' recommendations and the remainder from associated reviews or actions identified by the Health Board from its own analysis.

When the Panel last reported at the end of 2019, it concluded that 25 of the 79 MIP recommendations had been fully delivered up to that point, although some would require ongoing monitoring to ensure that they remained embedded in practice.

8.1 FURTHER PROGRESS AGAINST THE MIP

During January, February and March 2020, the Panel assessed further evidence provided by the Health Board and agreed that another 16 MIP actions were completed and ready to be 'signed off'. That brings the total number of actions now verified as completed to 41.

The Panel also assessed 3 other recommendations which the Health Board considered completed. However, the Panel did not feel that the evidence provided was sufficient to justify them being signed off. Further evidence has been requested and these actions will be presented for reassessment in the next reporting period.

That means that the Health Board has now delivered over half (52%) of the 79 recommendations in the MIP, with the remainder still work in progress. That is a significant milestone, particularly as many of the recommendations which have been delivered thus far, such as the revised clinical governance framework and the clinical audit programme, are fundamental building blocks for the delivery of others.

Some of the recommendations which have been delivered during this period are significant and others are the culmination of twelve months of planning and delivery. For example:-

- the bereavement service has been reviewed and improvements have been made, including the provision of information to ensure that appropriate support and counselling is available for all families[8];

- the maternity Governance and Risk team has now been resourced to ensure workloads are manageable and that Datix (a system for recording safety related incidents) records are reviewed, graded and actioned in an appropriate and timely manner;

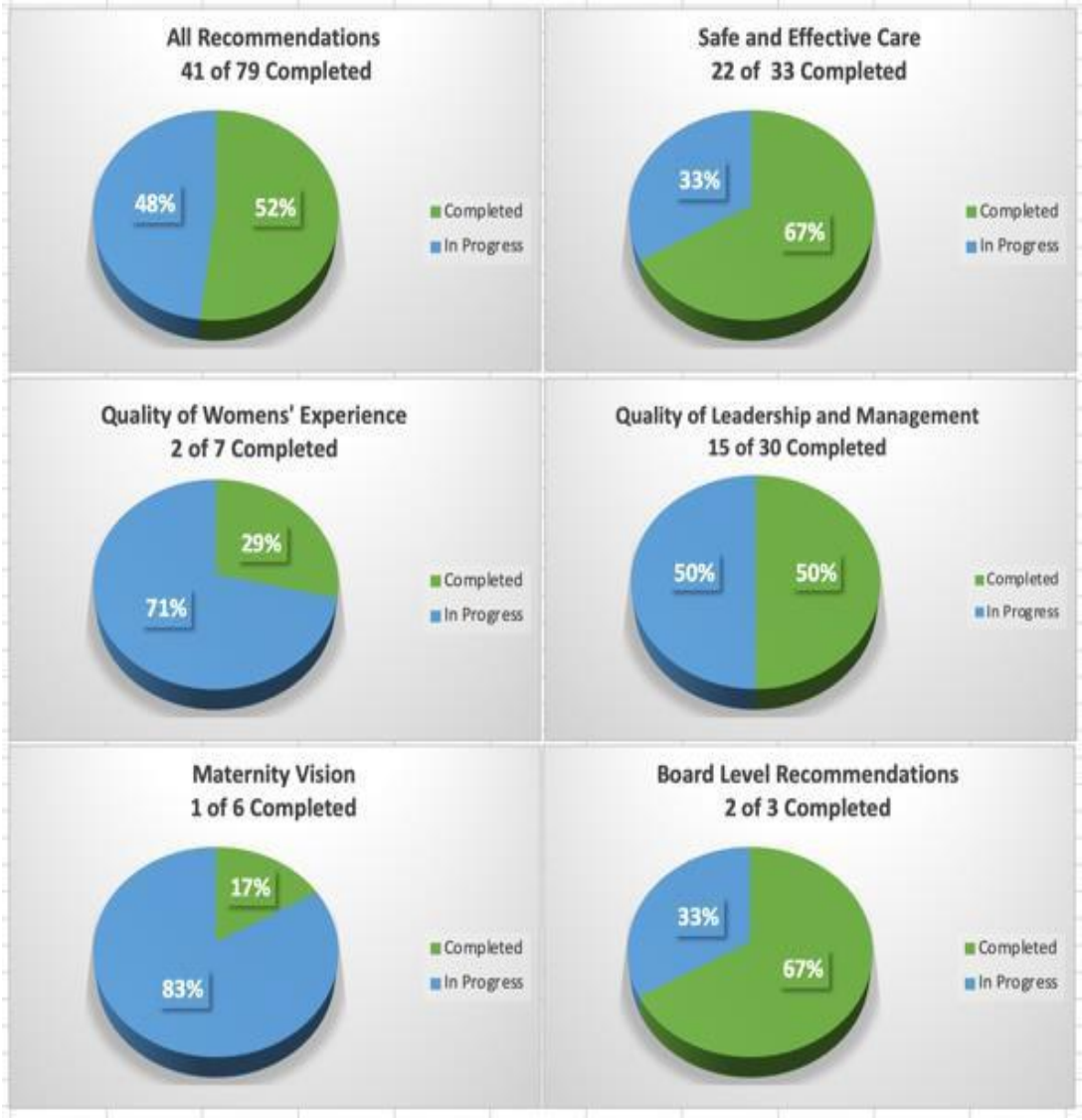
- all Independent Board Members have now been trained in the implications of the Corporate Manslaughter and Corporate Homicide Act 2007 to better understand their role in ensuring the safety of services provided by the Health Board[9];

[8] Albeit that a Task and Finish group has now been set up by the 'My Maternity My Way' forum to co-produce further enhancements (see section 4 of the report for further details).

- a mandatory training programme (including training in CTG, PROMPT and GAP and GROW[10]) has been designed and delivered for all medical and midwifery staff and high levels of compliance have been achieved[11].

The distribution of the 41 completed actions between the constituent Project Groups is illustrated in the figure below.

Figure 10: *Summary of Progress against MIP Recommendations by Project Group*



[9] One Board Member was unable to attend the training and has received personal input from the Board Chair.
[10] See glossary of terms in Section 11 of the report.
[11] A training plan was designed which would have achieved full compliance by 31 March 2020. However, training was suspended in mid-March due to the COVID-19 response and a small number of medical staff at the Prince Charles Hospital who were due to be trained at the end of March will now receive their training once normality has been restored. Notwithstanding that, the Panel considers that the action which RCOG recommended, has been fully delivered.

The remaining 38 actions are all work in progress in varying stages of completion. Although not sufficiently advanced to be signed off, there are a number where substantial progress has been made. For example:-

- the Health Board's 'Maternity Vision' (which sets out long term strategic aims aligned to the all-Wales Maternity Vision) has been developed and is now out for consultation with a range of stakeholders including women and families representatives;

- with the support of the NHS Delivery Unit, a substantial piece of work is being undertaken across the Health Board to improve the management of serious incident reporting and a standard checklist has been developed to ensure that the practice adopted in maternity services is consistent with that in other parts of the organisation;

- the leadership, mindfulness and corporate values training programmes (which are part of the wider organisational development plan) are being rolled out and the level of attendance and participation has been encouraging.

The latter is a significant development in the overall improvement journey. The programme is designed and delivered corporately to help bring about the longer-term change in culture and behaviours identified in the 'Listening to Women and Families' report which was published alongside the Royal Colleges' report.

During the current period, the Panel has also re-verified 5 further recommendations which were signed off in the previous quarter, in order to gain assurance that progress has been sustained and that the change has become embedded in practice. That included, for example, further checks around safety critical issues like consultant availability and response times and confirmation that key members of staff are routinely participating in governance related meetings and events.

Details of the 16 actions which were newly verified as 'signed off' during the quarter and the 5 actions which were re-verified are set out in the table at *'Appendix H'*.

8.2 OTHER INDICATORS OF IMPROVEMENT

Over the past three months, there has been less external review and inspection activity of the Health Board's maternity services than in previous reporting periods. As such, there has been less opportunity to triangulate the Panel's assessment against other forms of evidence.

There are however, various pieces of softer intelligence which supports the Panel's assessment that services are improving and that this is having a positive impact on the experience of women and families. For example, the twice weekly surveys conducted by the Health Board's Patient Advice and Liaison Service (PALS) have continued to demonstrate consistently high levels of satisfaction from women and families using the services at PCH[12].

[12] *The Panel has been made aware that the PALS survey process has been temporarily suspended due to the impact of the COVID-19 response and that a planned extension to the ante-natal service has been deferred.*

The Panel is also beginning to see more evidence of innovation, particularly in the way in which women and families are involved in the design and delivery of the service.

One such example is 'The Singing Unit', a collaborative venture between the Health Board and the University of South Wales which is exploring the use of music as a means of building bonds between babies and their parents in neonatal settings. A number of parents have been involved in the research programme and the results are encouraging.

There are other examples which have demonstrated further progress with embedding engagement at different levels within the Health Board. For example, family representatives were involved in the interview process for the appointment of the new Director of Midwifery and methods such as visual recording and storytelling, are increasingly being used for engagement with women and families.

8.3 Progress Against RCOG 'Make-Safe' Actions

When the Panel produced its first quarterly report in September 2019, it focused on assessing progress against the 11 'make-safe' actions which were identified by the Royal Colleges as requiring immediate attention due to potential safety implications.

Following an assessment of a range of evidence provided by the Health Board, the Panel concurred with the Health Board's assessment that 8 out of the 11 'make-safe' actions had been addressed and embedded into operational practice.

Although good progress had been made against the 3 remaining actions, at that stage, they continued to be work in progress. There were legitimate reasons for that and mitigation had been put in place to ensure that the service was safe whilst the remaining work was done.

During the current reporting period, the Panel have continued to monitor progress against the 3 recommendations which remained work in progress and an update on the current position is set out in the table overleaf.

Figure 11: *Progress against Outstanding 'Make-Safe' Actions as at 31 March 2020*

Action	Progress Update	Current Status
6. There was a lack of awareness of and accessibility to guidelines, protocols, triggers and escalations.	In the previous quarter, the Health Board reported that protocols were in place for both Prince Charles Hospital (PCH) and Royal Glamorgan Hospital (RGH) with further work to be done post-merger to align with Princess of Wales Hospital (POW). The Panel undertook some re-assurance work and confirmed that to be the case. The Health Board reported that alignment across the three sites was due for completion by March 2020. However, it is now recognised that this timescale was overly ambitious. Further work is now being done by the newly appointed Director of Midwifery to identify a more realistic timescale for the alignment to take place. The Panel acknowledges that progressing the alignment at POW with undue haste potentially carries a greater risk than a measured but slower approach.	**WORK IN PROGRESS** Upon closer scrutiny it has become clear that progress in this area has been slower than was first believed. That in part is due to a legitimate concern about the patient safety implications of introducing a significant number of revised policies in quick succession. As such, there is a backlog of guidelines that now require further updating and realignment. At the end of March, the Panel was provided with a prioritised schedule for completion of all updates on guidelines across the three hospital sites. The Panel will be closely monitoring progress against the plan during the next reporting period.
10. The midwifery staffing levels are not compliant with the findings of the Birthrate plus® review in 2017. The Health Board needs to monitor this in real time at a senior level, to assess if the established escalation protocols need to be invoked to ensure patient safety.	The Birthrate plus® Review was received by the Health Board in November 2019. The Maternity team took some time to review the findings. This was in part due to some additional work being required resulting in a short delay. The Director of Midwifery has confirmed that that the review indicated that existing establishment levels are consistent with Birthrate plus® recommendations and no additional resourcing is required. The Director has also advised that she is undertaking due diligence work in evaluating the distribution of the workforce and revisiting established escalation protocols. A comprehensive workforce plan will follow in the next reporting period. Action to reduce reliance on bank and overtime and bring staffing levels up to funded establishment is being taken with the majority of vacancies now filled and numbers being maintained on a business as usual basis. Staffing availability continues to be monitored by the Health Board on a daily basis and by the Welsh Government through a weekly monitoring process.	**WORK IN PROGRESS** The Panel are monitoring staffing levels through the Welsh Government's weekly maternity monitoring process to ensure compliance with the levels which have previously been agreed with the Health Board and are now confirmed as appropriate by the Birthrate plus® Review. The Panel have asked to see the workforce plan when it is completed and will reassess whether the recommendation can be signed off during the next reporting period. It is recognised that the plan may take some time to develop as it is linked with work which is ongoing at an all-Wales level.

Action	Progress Update	Current Status
11. The culture within the service is still perceived as punitive. Staff require support from senior management at this difficult time.	Staff and leadership development activity continues to be delivered at pace. Whilst it is early days, there are now indications of increasing staff capability and capacity in support of a more systematic approach to service user engagement and quality improvement. Culture change takes time and thoughtful system redesign to shape appropriate values and behaviour. It is still too early to sign this off as completed.	**WORK IN PROGRESS** This will be formally reviewed again once the corporate leadership and organisational development programmes are more firmly established across the Health Board.

Although progress is being made against the three residual 'make-safe' recommendations, the Panel had expected to see more progress during the last quarter in respect of Action 6 (policies and procedures) and Action 10 (Birthrate plus®).

It is important to emphasise that whilst these issues need to be progressed as a matter of priority, there are mitigations in place to ensure that safety is not compromised. It would also be fair to acknowledge that the new Director of Midwifery has only been in post for just over two months and understandably, is taking some time to review what has been done up to this point and what needs to happen going forward. This has slowed down the pace of progress to an extent, but will ultimately pay dividends if the eventual outcomes are enhanced. The new Director has impressed the Panel with her knowledge and understanding and she is bringing new and valuable insights to the improvement process.

The Health Board has been made aware that 'make-safe' Actions 6 and 10 will be areas for particular focus during the next reporting period and the Panel will continue to press through its regular meetings for more pace, albeit that the level of expectation will need to be realistic given the impact of COVID-19.

NEXT STEPS - Action 8: Whilst the Birthrate plus® Review has confirmed that existing staffing levels are appropriate, the Panel awaits the development of a longer term workforce plan which shows how those resources will be optimised (e.g. by reducing sickness and the use of overtime) and how deployments will be adjusted to reflect changing patterns of demand and new ways of working.

NEXT STEPS - Action 9: Whilst progress has been made in ensuring that policies, protocols and guidelines are readily available and accessible to staff, a significant number of policies now require review and updating. The Panel was provided with a prioritised schedule of reviews at the end of March 2020 and will expect to see substantial progress against this during the next reporting period.

8.4 Assessment of Current Position

Taking everything into account, good progress has been made against the MIP during the period under review meaning that over half of the 79 actions have been delivered and embedded in operational practice.

Many of those actions are what could, for want of a better term, be described as 'big-ticket items' which have created the foundations for further improvement.

The early actions to address the 'make-safe' issues identified by RCOG as requiring immediate attention have been consolidated further, although as outlined in Section 1.3 above, a concerted effort is required in the next period to finalise the work which has been started around staffing levels and policies, procedures and guidelines.

Whilst the Health Board should be satisfied with what it has achieved over the past 12 months, the fact remains that there is a significant amount of work still to be done to deliver the whole plan and many of the actions which remain are long term developments linked to organisational culture and outcomes.

The reality of the current situation is that delivering at pace will be a challenge during the next period given that the Health Board's focus will inevitably be drawn into the COVID-19 response. However, the Panel will do what it can, in a proportionate way, to ensure that the focus on delivering against the MIP is maintained and there is a continued focus on the safety and welfare of women and families.

What is encouraging, is that the adjustments which were made to the structure and capacity of Maternity Improvement Team in the early part of January have had an impact. There is now a much more disciplined approach to the collection and recording of evidence which bodes well for the next period. Whether that capacity can be maintained in short term, against the background of the COVID-19 response, will need to be closely monitored.

NEXT STEPS - Action 10: Recognising current constraints, the Panel expects to see further delivery against the remaining recommendations within the MIP during the next reporting period and a continued focus on embedding and testing those recommendations which have already been delivered.

8.5 Developing the Maternity Improvement Plan

When the Panel reported in January 2020, it expressed a degree of frustration about the pace of progress in further developing the Maternity Improvement Plan to include clearer milestones, targets and deliverables.

In January, additional resources were brought into the Maternity Improvement Team and there were changes in structure which provided increased capacity. The Maternity Improvement Director was then able to focus more time and energy on developmental issues. As a result, the Plan has now been enhanced to include clear timescales and milestones for delivery. A schematic which provide a high-level overview of the revised Plan is attached at *'Appendix G'*.

The high-level plan now provides a broad indication of what the Health Board is intending to deliver over the next 12 months, when individual pieces of work will be scheduled and who is responsible for each element of the plan.

The high-level plan is supported by a series of individual project plans, one for each of the performance domains, which provides more detailed actions and timescales. And whilst the link back to the Royal Colleges' recommendations has been maintained, it is now a plan which is more about delivering improvement over time, rather than simply ticking off a long and sometimes overlapping list of historical actions.

Over the next period, the Panel would like to see the MIP developed further with a particular focus on two issues. Firstly, the plan needs to become more dynamic. There is a need to move beyond the delivery of what remains of the 79 recommendations to a situation where any additional actions which emerge from the Health Board's continuous improvement work can be assimilated into the plan.

Secondly, there is an opportunity to rationalise the current plan. As a greater proportion of the original 79 recommendations have been delivered, it has become increasingly apparent that there is some overlap and duplication in the remaining recommendations. Others recommendations are no longer as relevant due to changes in circumstances which have occurred since the Royal Colleges' review. This might be particularly helpful in the current environment and the Panel is keen to support this work whilst capacity is stretched due to the COVID-19 response.

In summary, the adjustments which have been made to the MIP in the previous quarter are a significant step forward. However, the Panel believes that there are opportunities to further enhance this moving forward.

NEXT STEPS - Action 11: The MIP would benefit from some further development to create a more dynamic, more responsive plan which is regularly refreshed to ensure that it delivers continuous improvement rather than a list of recommendations.

NEXT STEPS - Action 12: The remaining MIP actions should be reviewed and where appropriate rationalised, consolidated or grouped to avoid duplication and to identify those recommendations where changes in circumstance mean they are no longer relevant.

8.6 HEALTHCARE INSPECTORATE WALES – INSPECTION PROGRAMME

In the previous quarter, Healthcare Inspectorate Wales (HIW) published its report into an unannounced three-day inspection of the Tirion Birth Centre at RGH in September.

The report concluded that '*care was provided in a safe and effective manner'* whilst *'staff demonstrated a clear passion and drive to provide high standards of care to patients, in a homely, relaxed environment*'. There were a small number of areas for improvement, but these did not indicate fundamental weaknesses within the service.

The Tirion inspection was reassuring in that there was a significant degree of triangulation between the HIW inspection team's conclusions and what the Panel had experienced during its visits to the Centre and in its broader assessment of evidence of delivery against the MIP.

In the current quarter, HIW published its report of an unannounced inspection of the consultant-led service at PCH which was conducted in early November 2019. The report concluded that whilst care was provided *'in a respectful and dignified way'* the inspection team had identified that '*a number of improvements were required to ensure that the service was providing safe and effective care at all times*'.

There were positives which could be drawn from the PCH report, not least evidence of appropriate staff attitudes and behaviours, positive feedback from women who used the service and positive feedback from staff about the quality of the leadership which they experienced. Those aspects of the report were reassuring because they concurred with the Panel's experience and were in stark contrast to what the Royal Colleges found when they were conducting their review ten months earlier. However, other aspects of the report were less reassuring.

Not all of the areas for improvement which were identified by the HIW inspection team were safety critical. Indeed some (including the absence of information about smoking cessation and the lack of information about advocacy support) were simply and immediately rectified. Others (for example, the failure to record regular checks of equipment and poor security of medicines and patient records) pointed to the need for more rigorous audit processes and closer supervision. The majority of those issues were also remedied immediately following the post-inspection briefing provided by the HIW inspection team.

However, a smaller number of issues (such as concerns about the adequacy of the security arrangements, the failure to conduct regular checks of essential equipment and weaknesses in the handover process) were such that the HIW inspection team were unable to provide assurance about the safety and effectiveness of the service.

As a result, the Panel commissioned a 'triangulation exercise' to identify and where necessary, address any significant anomalies between the Panel's assessment of progress and the HIW findings. This included a review of the management response and an assessment of the progress which had already been made against the action plan which accompanied the management response.

Having reviewed the outcome of the triangulation exercise, the Panel was reassured that there was a significant degree of correlation between its own assessment and the findings of the HIW unannounced inspection. Where there was variation, particularly in terms or providing assurance (or the inability to provide assurance) that the service was safe and effective, much of that could be explained by the differing nature of two assessments[13] and variation in the timing of the assessment[14].

[13] *The Panel is essentially looking for evidence which will provide assurance that the necessary strategies, systems and processes have been put in place to provide a safe and effective service; the HIW inspection is assessing the way in which those strategies, systems and processes are being implemented in practice based on a snapshot in time.*

[14] *The Panel's assurance was based on the assessment of evidence provided by the Health Board in December 2019. The HIW inspection was conducted between 02 and 04 November 2019.*

The Panel was also reassured, having reviewed the actions plans which the Health Board prepared in response to the HIW report that the majority of the actions had already been addressed and work was ongoing in the small number where that was not the case. However, there were two particular areas where the Panel felt that it needed to seek further assurance via its regular assurance checks in the next reporting period, namely:-

(i) **Handovers** - the HIW inspection identified concerns about the robustness of the handover process whereas the Panel had previously 'signed off' the process as fit for purpose based on a package of evidence provided by the Health Board (albeit that the Panel had not had the opportunity to observe a handover meeting in practice);

(ii) **Assurance Audits** - the HIW inspection identified weakness in the application of assurance audit process whereas the Panel had previously 'signed off' the process itself as fit for purpose based on its own observations and the assessment of a package of evidence provided by the Health Board.

The Panel is conscious of the need to avoid encroaching on HIW territory and will monitor the Health Board's formal responses in order to gain the assurance it needs that the areas for improvement identified in the inspection report have been fully addressed. In order to achieve that without creating unnecessary duplication of effort, the Health Board has been asked to provide the Panel with an exception report in respect of any actions which remain outstanding after the end of March 2020.

NEXT STEPS - Action 13: As part of the regular meeting cycle, the Health Board has been asked to provide the Panel with an exception report in respect of any actions arising from the HIW unannounced inspection of Prince Charles Hospital which remain outstanding after the end of March 2020.

NEXT STEPS - Action 14: The Panel will include a further review of handovers and assurance audits in its programme of reassurance checks for the next reporting period.

9 CONCLUSIONS, NEXT STEPS AND RECOMMENDATIONS

9.1 OVERALL ASSESSMENT OF CURRENT POSITION

Building on the solid foundations which were created during 2019, the Panel is pleased to report that the Health Board has made **further progress** during the first quarter of 2020.

The Panel now believes that the Health Board is **firmly on track**, not only to deliver against the Royal Colleges' recommendations, but also, in due course, to deliver a maternity service which they, their staff and the communities they serve can be proud of. The rationale for that assessment is as follows:-

- the 'make-safe' issues identified have largely been addressed;
- where 'make-safe' issues remain work in progress, mitigations are in place;
- there is evidence of further delivery against the Maternity Improvement Plan;
- there are signs that the service is improving for women and families;
- there are growing signs of a change in staff attitudes and behaviours;
- the right leadership is now in place;
- multi-disciplinary working is more cohesive;
- there are clinical governance and clinical audit processes in place;
- the initial phase of engagement has been completed with positive outcomes;
- the clinical review programme has now commenced in earnest;
- the Health Board is engaging constructively in the improvement process;
- the improvement framework which has been put in place is working well;
- the IPAAF and the MIP have been further developed;
- an initial baseline assessment has now been conducted;
- there is evidence of 'early progress' against all three of the IPAAF domains.

Despite the obvious progress which has been made, there is still much work to be done. Just under half of the 79 recommendations in the Maternity Improvement Plan are still work in progress and there is more to do through the wider organisational development programme to embed the changes in culture and behaviours which are now emerging.

Similarly, although resource levels are now known to be in line with expected levels, there is still work to be done to ensure that those resources are being deployed in the most effective way (sickness rates, for example, remain too high). Moreover, whilst policies, protocols and guidelines are now readily accessible to staff, the Panel has recently discovered that a significant number of those need to be reviewed and updated.

In terms of outcomes, work is still ongoing to understand why, for example, the rates for induction of labour appear to be higher than in other Health Board areas and what, if anything, needs to be done to address that. At the same time, good progress has been made in the way that the Health Board engages with women and families who use the service, although there is still work to be done to ensure that the feedback from engagement begins to drive changes in practice and improvements in user experience.

At the corporate level, although there are signs of improvement in the way that concerns and complaints are managed, the inability to routinely resolve historical complaints effectively is still impacting on the trust and confidence of women who have been adversely affected.

9.2 NEXT STEPS

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

- **Action 1: Thematic Analysis** - The Panel awaits the publication of the thematic analysis of the outcome of the three engagement events held during 2019/20 together with the detailed action plans which emerge from it.

- **Action 2: Engagement Plan for 2020/21** - The Panel looks forward to the publication of the Maternity Services Engagement Plan for 2020/21 and in particular, to the launch of the feedback monitoring tool which is currently being developed.

- **Action 3: Complaints and Concerns** - Once approved, the Panel will expect the Complaints and Concerns Improvement Plan to be a regular feature of the Health Board's performance reporting and will expect to see relevant performance metrics included within the next phase of development of the IPAAF.

- **Action 4: IPAAF** - Further development work is required to consolidate the progress which has been made in developing metrics for the IPAAF, particularly in terms of (i) identifying performance thresholds or targets where appropriate, (ii) supplementing areas where the metrics are limited (especially Quality of Women's and Families' Experience) and (iii) ensuring continued alignment with the emerging all-Wales performance framework.

- **Action 5: Maturity Matrix** - Further development work is required to identify outcome-based measures which will enable an objective assessment to be made about what, in each of the performance domains, constitutes achievement of the 'Results', 'Maturity' and 'Exemplar' elements of the Maturity Matrix.

- **Action 6: Maternity Improvement Team** - The Panel looks forward to receiving the SRO's proposals for replacing the Maternity Improvement Director when she moves on to her new role.

- **Action 7: Neonatal Services** - During the next reporting period, the Panel will pay increased attention to the neonatal service and as a first step, will invite the Consultant Neonatologist to attend the next Panel meeting to provide an overview of the service.

- **Action 8: Staffing Levels** - Whilst the Birthrate plus® Review has confirmed that existing staffing levels are appropriate, the Panel awaits the development of a longer term workforce plan which shows how those resources will be optimised (e.g. by reducing sickness and the use of overtime) and how deployments will be adjusted to reflect changing patterns of demand and new ways of working.

- **Action 9: Policies, Protocols and Guidelines** - Whilst progress has been made in ensuring that policies, protocols and guidelines are readily available and accessible to staff, a significant number of policies now require review and updating. The Panel was provided with a prioritised schedule of reviews at the end of March 2020 and will expect to see substantial progress against this during the next reporting period.

- **Action 10: Maternity Improvement Plan (Delivery)** - Recognising current constraints, the Panel expects to see further delivery against the remaining recommendations within the MIP during the next reporting period and a continued focus on embedding those recommendations which have already been delivered.

- **Action 11: Maternity Improvement Plan (Development)** - The MIP would benefit from further development to create a more dynamic, more responsive plan which is regularly refreshed to ensure that it delivers continuous improvement rather than address a list of recommendations.

- **Action 12: Maternity Improvement Plan (Rationalisation)** - The remaining MIP actions should be reviewed and where appropriate rationalised, consolidated or grouped to avoid duplication and to identify those recommendations where changes in circumstance mean they are no longer relevant.

- **Action 13: HIW Unannounced Inspection** - As part of the regular meeting cycle, the Health Board has been asked to provide the Panel with an exception report in respect of any actions arising from the HIW unannounced inspection of Prince Charles Hospital which remain outstanding after the end of March 2020.

- **Action 14: Handovers and Assurance Audits** - The Panel will include a review of the handovers and assurance audits in its programme of reassurance checks for the next reporting period.

These actions will be monitored through the established assurance process and progress will be reported upon when the Panel produces its next report later in the year. However, for reasons which are explored in the following paragraph, the Panel's expectations may need to be tempered as the longer-term implications of the COVID-19 response become clearer.

9.3 PROSPECTS FOR FURTHER IMPROVEMENT

The Health Board has created a solid platform for further improvement and, in so far as its maternity services are concerned, it is in a very different place than it was 12 months ago when the Royal Colleges' report was published.

However, the Panel is conscious that in the short term at least, the Health Board may find it difficult to maintain the focus and commitment that is needed to build substantially on the platform it has created.

The most significant threat to progress over the next few months is, without doubt, the need to respond to the COVID-19 outbreak. It is almost inevitable that the Health Board's focus, energy and resource will be drawn away from existing priorities like the Maternity Improvement Programme and directed towards what is clearly a more pressing issue.

The Health Board is already seeing the impact of increased sickness on staffing levels within the maternity and neonatal units. Senior managers have, with good reason, already been diverted from their day to day involvement in the improvement process and some services have had to be temporarily diverted.

Even if the impact of the virus is contained within reasonably short time scales, it is clearly going to take some time for the organisation to recover. As such, the Panel is under no illusion that in the short term, it is going to be hugely challenging for the Health Board to maintain the level of focus and commitment it has been providing to this point.

However, it is important that the progress which has been made, particularly in terms of the quality and safety of the service provided, is not lost and the Panel will do what it can to ensure that the focus on those critical areas is maintained. In support of that, the Panel will work with the Health Board to identify those less critical aspects in the outstanding balance of the Maternity Improvement Plan which can be put on hold for the time-being.

In response, the Senior Responsible Officer has made a commitment that he will do everything possible to ensure that staffing levels within the Maternity Improvement Team are protected for as long as possible, particularly those involved in supporting the Clinical Review Programme.

It is not all doom and gloom though and from adversity, opportunity often emerges. The Panel is already seeing some of the learning from the past 12 months reflected in the Health Board's response. For example, learning from the engagement and communication work which the maternity services team has been conducting was evident in their response to COVID-19, including the provision of clear, timely and compassionate messaging for women and families who might be concerned about the impact on their pregnancy.

But while COVID-19 is undoubtedly the most significant threat to the prospect of further improvement, there are a number of other factors which will need to be carefully managed by the Health Board over the next few months to ensure that the focus and momentum which has been created is not lost. This includes:-

- the departure of the Maternity Improvement Director who has secured a new post in the Health Board and is moving on imminently to support the COVID-19 response;

- enforced changes within the Maternity Improvement Team and a subsequent loss of knowledge and experience which may be difficult to replace;

- the appointment of the new Director of Midwifery, who is bringing new experience and insight but is understandably taking time to review the existing approach.

The Health Board is equally conscious of these issues and is actively working with the Panel to find ways in which the risk of a loss of momentum can be mitigated.

In particular, proposals to address the impact of the departure of the Maternity Improvement Director and other changes in the Maternity Improvement Team are currently being developed.

9.4 RECOMMENDATIONS

In view of the progress which has and continues to be made and the ongoing commitment which the Health Board has shown to the improvement process, the Panel does not feel that it is necessary to make specific recommendations for the Health Board to consider at this stage. The report does, however, make one recommendation which the Minister is invited to consider and that relates to the frequency of the reporting cycle.

When the oversight process was established in April 2019, the Panel committed to report progress to the Minister on a quarterly basis. This is the Panel's third quarterly report.

In the early stages of the process, a three-month cycle was entirely appropriate given the scale and complexity of the issues to be tackled and the level of public, media and political interest in the issue. However, given the progress which the Health Board is making, it now seems appropriate for the frequency to be reviewed.

The majority of the short-term priorities within the Maternity Improvement Plan have now been delivered and what remains are the longer-term issues, like culture change and restoring public confidence, which will take time to affect. As such, the volume of demonstrable progress which is going to be delivered in a three-month period will become less and less as time progresses.

The Panel was intending to recommend that the reporting cycle be extended long before the COVID-19 situation emerged. However, this now provides added weight to the argument for an extension, given the additional pressures that the Health Board is operating under and the need to reduce, as far as is safe and reasonable, its administrative workload. For those reasons, the Panel is proposing that the reporting cycle be extended to six months with the next report being presented to the Minister at the end of September 2020 and the subsequent report being presented at the end of March 2021.

If the recommendation is agreed, then the Panel will reduce its formal meeting cycle from monthly to bi-monthly and its informal meeting cycle from weekly to bi-weekly. This will not only free up capacity for the Health Board but will also enable the Panel to focus more of its time and energy on progressing the Clinical Review Programme. If agreed, the Panel will also continue with the current practice of providing an informal monthly update to the Welsh Government and to meeting with the SRO, CEO and Chair in the period between formal meetings. On that basis, the Panel's recommendation is as follows:-

RECOMMENDATION 1: The Minister is asked to approve an extension of the current reporting cycle from three months to six months with the next progress report being presented to the Minister at the end of September 2020 and the subsequent report being presented at the end of March 2021.

10 LIST OF APPENDICES

Appendix A: Terms of Reference

Appendix B: Clinical Review Pathway

Appendix C: Self-Referral Pathway

Appendix D: Integrated Performance Assessment and Assurance Framework

Appendix E: IPAAF Metrics by Domain

Appendix F: Maturity Matrix

Appendix G: High Level Maternity Improvement Plan

Appendix H: Schedule of Completed Maternity Improvement Plan Recommendations

Appendix I: IMSOP Statement - Response to COVID-19

Appendix A

Independent Maternity Services Oversight Panel

Terms of Reference

Purpose of the Independent Oversight Panel

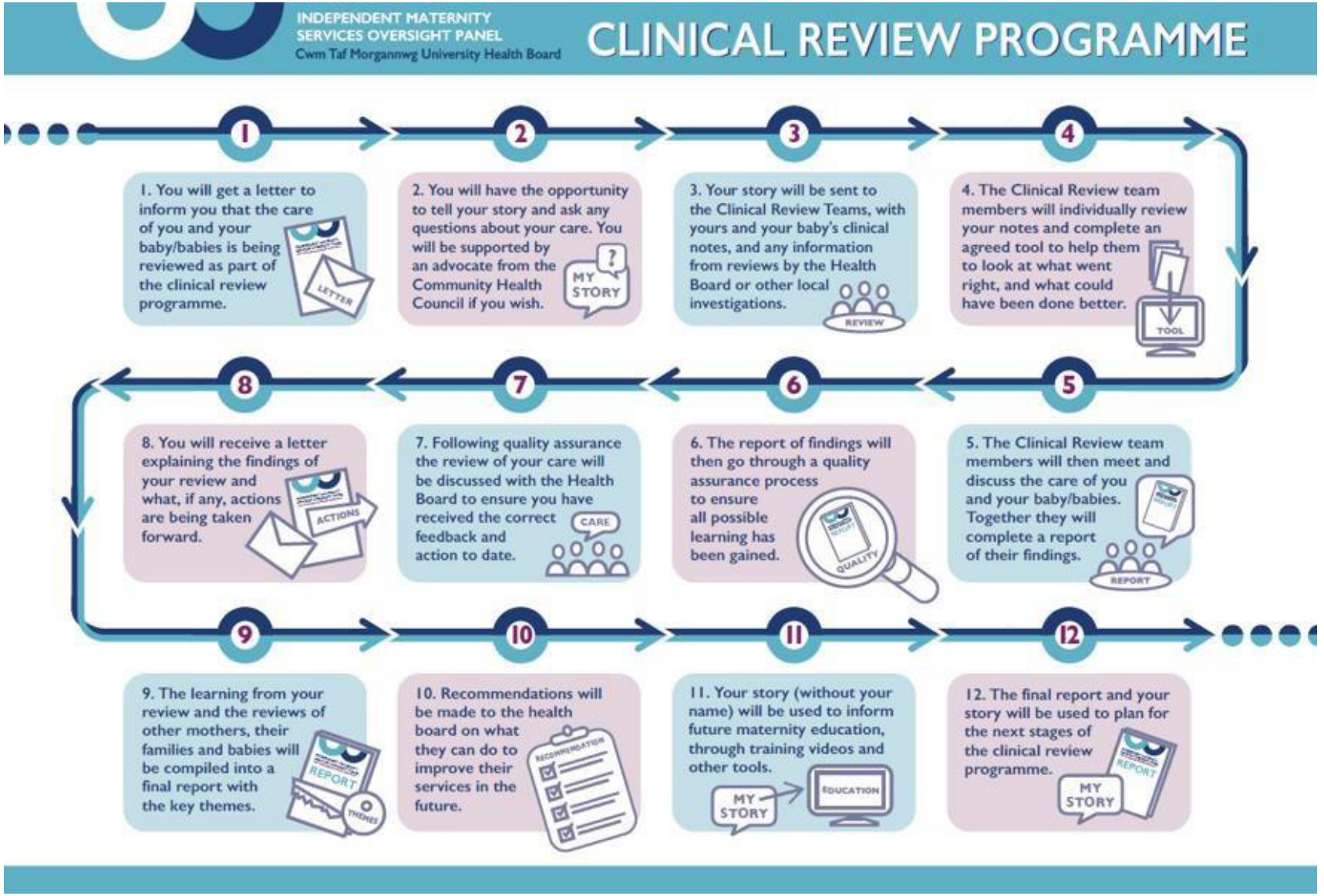
Provide the oversight[1] which is necessary to enable Cwm Taf Morgannwg University Health Board to implement the recommendations of the Royal Colleges' report in a timely, open and transparent manner.

Terms of Reference

- Establish robust arrangements which provide assurance to stakeholders that the recommendations of the Royal Colleges' review and other associated recommendations are being implemented by the Health Board. Set and agree milestones and deliverables and track progress against them;
- Establish and agree an independent multidisciplinary process to clinically review the 2016-2018 serious incidents identified by the Royal Colleges as requiring further investigation. Conduct a 'look back' exercise to 2010 and ensure that anyone who has justified concerns about their care is provided with the opportunity for it to be reviewed. Ensure that any learning which emerges from these reviews is acted upon by the Health Board and others;
- Advise the Health Board on the actions it needs to take to establish effective engagement arrangements which actively involve patients and staff in the improvement of maternity and neonatal services and rebuild wider public trust and confidence in the Health Board;
- Escalate any wider governance related issues or concerns which emerge to the Health Board and Welsh Government as appropriate;
- Advise the Minister on any further action which the Panel considers necessary to ensure the provision of safe, sustainable, high quality, patient centred maternity and neonatal services. This should include advice about the need for, and timing of, any follow-up independent reviews and the identification of any wider lessons for the NHS in Wales.

[1]By the term 'oversight' we mean an objectively derived blend of measures (including target setting, monitoring, scrutiny, challenge, reality testing, guidance, encouragement and support) which in combination, provide assurance to stakeholders (including patients, staff and the wider public) that the Health Board is delivering the improvements which it is required to deliver.

Clinical Review Pathway



Self-Referral Pathway

Self-Referrals

How we're managing Self-Referrals

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

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

1

PUTTING THINGS RIGHT (PTR)

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

2

INDEPENDENT CLINICAL REVIEW

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

3

SELF-REFERRAL

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

Self-Referral Team

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

Emotional Support

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

How to contact

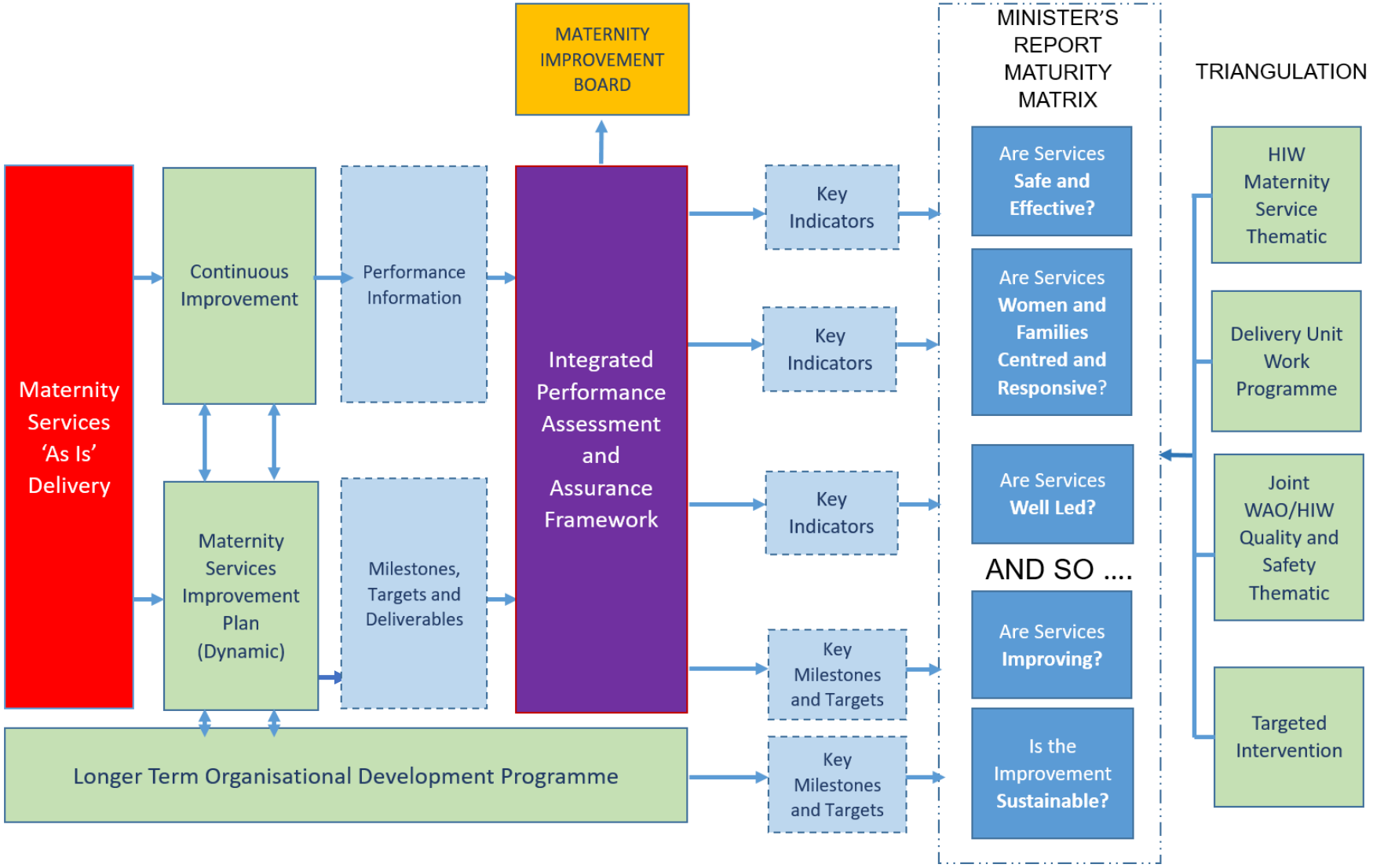
CTUHB_Concerns@wales.nhs.uk

or

01443 744915

Cwm Taf Morgannwg University Health Board

Integrated Performance Assessment and Assurance Framework



Integrated Performance Assessment and Assurance Framework – Key Metrics by Domain

Safe and Effective Care

- Total Births
- % Initial Assessment by 10 Weeks
- % Women Delivered by Midwife / Consultant
- % Induction of Labour
- Normal Birth (SVD) Rate
- % Low Risk Women Commencing / Completing NLP
- % VBACS Attempted / Successful
- No. Instrument Deliveries Attempted / Failed
- % Caesarean Section - Elective / Emergency / Total
- % Third and Fourth Degree Tears
- % Massive Post Partum Hemorrhage (>2 Litres)
- Unexpected Term Admissions to Neonatal Unit
- No. Still Births
- No. Neonatal Deaths within 24 Hours
- No. Serious Untoward Incidents
- Neonatal Bed Occupancy Rate

Quality of Women's Experience

- % Sickness
- % PDR Compliance
- Job Plan Compliance (By Head Count)
- % Training Compliance Doctor / Midwives/Midwives
- % Completion of Leadership and OD Training
- Staff Wellbeing
- Staff Turnover Rate
- Midwifery Staffing Uplift
- Midwifery Staffing Ratio (Registered / Unregistered)

Quality of Leadership and Management

- Total Complaints Received
- % Complaints Response within Target
- % Reopened Complaints
- Maternity Response 10 Domains (PALS)
- Wordle Comments (More of, Less of)
- Maternity PREM
- No of Maternity My May Way Meetings
- No of Engagement Events
- No of Social Media Responses

Maternity Improvement Maturity Matrix – Safe and Effective Care Domain

Progress Levels ⇨ **Key Elements** ⇩	**BASIC LEVEL** Principle accepted and commitment to action	**EARLY PROGRESS** Early progress in development	**RESULTS** Initial achievements achieved	**MATURITY** Results consistently achieved	**EXEMPLAR** Others learning from our consistent achievements
SAFE AND EFFECTIVE CARE	The health board recognises that improvements are required to the delivery of safe and effective care. There is a commitment to develop systems and processes to facilitate this improvement.	The health board has a developing quality governance structure and has full engagement from all of the MDT. The health board has a developing quality dashboard and monitors key indicators. Clinical incidents are reported and investigated appropriately and learning is focussed on individual incidents. Changes in practice are recommended but there is limited evidence that these changes are implemented and/or impact on future safety. Responsibility for patient safety and governance is limited to a few key individuals in the maternity service. The Health Board recognises the importance of support required for bereaved families. Monthly support group meetings taking place.	There is evidence that there is thematic analysis of clinical incidents and that clinical practice is influenced by this learning. There is evidence that changes in practice prevent future incidents of a similar nature. Learning from incidents is shared widely across the service and both clinicians and managers can evidence how this learning influences their own practice. There is a management led audit programme and clinicians are involved in conducting audit. There is evidence that the health board takes corrective action where care is not delivered to accepted standards of practice. There is a developing plan to address the Welsh Government 5 year Maternity Vision recommendations. There is an emerging interest in quality improvement and the maternity service has some success in small tests of change.	There is recognition that systems contribute to clinical incidents and the maternity service evidences human factors and system changes to prevent incident repetition. The Maternity Service is outward looking and can evidence that it learns from the experience of other services. There is evidence that the health board recommendations in the Welsh Government Maternity Vision are well embedded. The health board recognises good practice and amplifies and spreads this across all aspects of the service. There is a strategic approach to quality improvement and evidence that QI initiatives are impacting on key metrics. All staff recognise that patient safety and quality improvement is part of their role. Clinical audits consistently demonstrate that health board practice delivers care to accepted standards of practice. Since the development of the bereavement guidance folder there has been NO paperwork errors.	A culture of continuous quality improvement is embedded within the health board and is integral to decision making at all levels. The maternity service is a centre of excellence, continually assessing and comparing its performance against others both within and outside the health service. Clinicians in the health board are engaged in local and national research. Teams design and conduct their own audit and QI programmes, which are outcome focussed and in collaboration with women, families and the public. The need for protocols and policies is reduced as evidence based practice becomes second nature and staff are alert to safety risks.

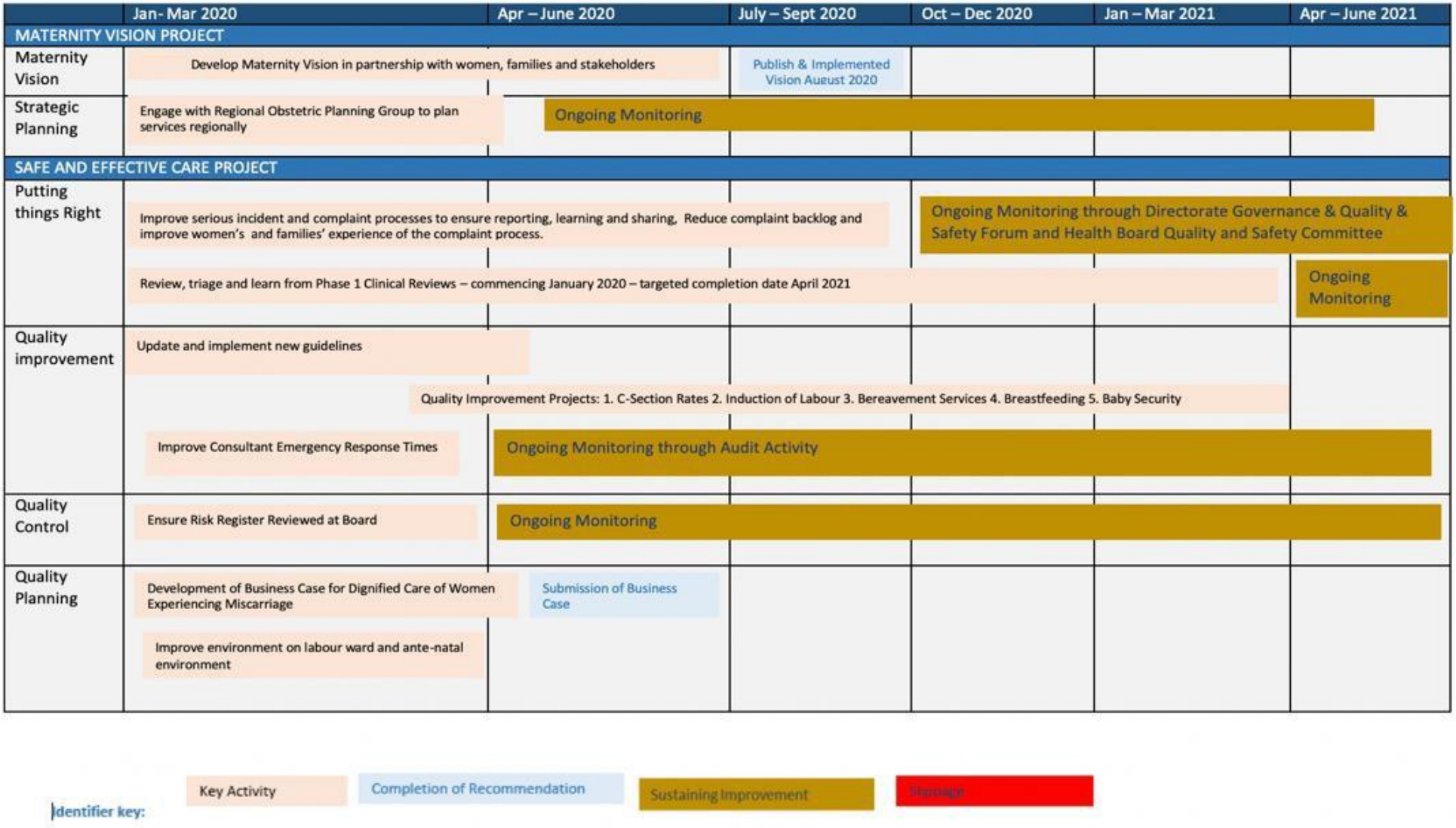
Maternity Improvement Maturity Matrix – Quality of Women's Experience Domain

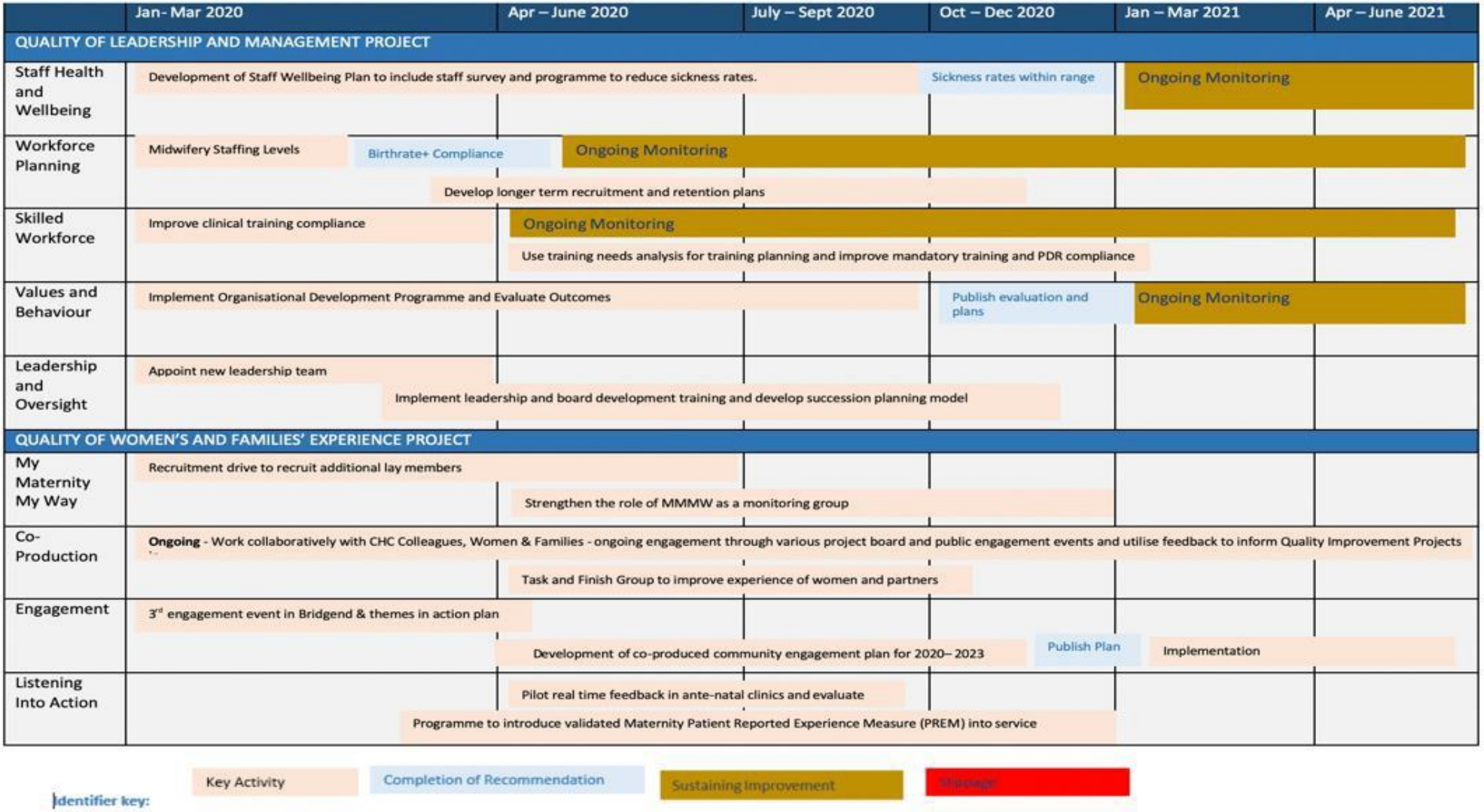
Progress Levels ➡ **Key Elements** ⬇	**BASIC LEVEL** Principle accepted and commitment to action	**EARLY PROGRESS** Early progress in development	**RESULTS** Initial achievements achieved	**MATURITY** Results consistently achieved	**EXEMPLAR** Others learning from our consistent achievements
QUALITY OF WOMEN'S AND FAMILIES EXPERIENCE	The health board recognises that that engagement and involvement extends from receiving information through to involvement in an individual's direct care planning through to the planning of services. The health board recognises that it has an under-developed approach to engagement and is developing a plan to improve.	The health board informs women and families of issues related to their care or planned changes to service delivery. The health board seeks the views of women and families at key points in the care pathway and works to address their individual issues. Learning from experience is largely focussed on Putting Things Right.	The health board has multiple and sophisticated means of seeking the views of women and families and aggregates and analyses these views to inform service delivery. The health board can evidence that service user engagement has impacted on the delivery of the service. The health board has an appreciative enquiry approach and amplifies good practice across the service.	The health board proactively works with women and families in all aspects of service delivery and women and families are actively involved in health board activity, such as recruitment, committee meetings etc. There is evidence that patient stories are used extensively across all activities e.g. training, supervision etc. The MSLC is a key collaborator in the development of Maternity Services. Women and families who complain about their experience are satisfied that that their experience impacts on future practice. Fewer women choose to ask for their complaints to be reviewed by the Public Services Ombudsman.	The health board shares innovate engagement and involvement practices with others. These engagement and involvement practices are co-produced with people with lived experience. There is consistent evidence that women choose to have their maternity care in Cwm Taf Morgannwg. Even though feedback from women and families is consistently positive, the health board proactively engages women and families to consider further improvements and enhancements to the service, asking not 'what does good look like?' but 'what would outstanding look like?'

Maternity Improvement Maturity Matrix – Quality of Leadership and Management Domain

Progress Levels ➡ **Key Elements** ⬇	**BASIC LEVEL** Principle accepted and commitment to action	**EARLY PROGRESS** Early progress in development	**RESULTS** Initial achievements achieved	**MATURITY** Results consistently achieved	**EXEMPLAR** Others learning from our consistent achievements
QUALITY OF MANAGEMENT AND LEADERSHIP	The health board recognises that it needs to improve staff experience, staff development and leadership direction. The health board is developing a plan to address the quality of leadership and management.	The health board monitors staffing levels and takes action to address shortfalls. The health board has a plan to improve recruitment and retention. Training compliance and PADR/appraisal rates are monitored. There are plans in place to improve compliance. The health board responds reactively to external oversight. There is evidence that the plan to improve the quality of management and leadership is accepted and endorsed by maternity services staff and staff side representatives.	The health board is compliant with Birthrate+ and staffing levels recommendations from professional bodies. There are escalation procedures when staffing levels fall below required standards. The health board is able to release staff for training and mandatory/statutory and other core training compliance rates are consistently good. The health board understands the key components of psychological safety, patient safety culture and good staff experience and is beginning to demonstrate improvements. The health board recognises that it needs to develop the leadership potential of its existing workforce and has emerging leadership programmes in development. There are clear roles, responsibilities and lines of accountability across the service. There is evidence of team work across professional disciplines There is an emerging staff engagement strategy and multiple means for staff to share their views and experiences. The health board is proactive in providing assurance.	There is a strategic approach to workforce planning and evidence of well-established plans to meet clinical requirements in the future. There are well developed in-house training programmes. The health board training needs analysis is reviewed annually in line with changes to clinical evidence and there is a robust training infrastructure to ensure that clinical staff are well developed. Staff feel confident to constructively challenge their peers and the organisational culture when they recognise that there are practices that impact on psychological safety and staff experience. Leaders are well supported, outward looking and committed to continuous learning. There are well developed peer networks and constructive challenge and feedback is common place. There is robust evidence that staff feedback informs service planning and changes in practice. Managers have constructive working relationships with staff side partners and work in partnership to deliver workforce improvements.	There is evidence that clinicians choose to work in Cwm Taf Morgannwg due to its reputation for high quality care and staff experience. Staff turnover is low. Quality improvement initiatives are also focussed on continuously improving staff experience. Cwm Taf Morgannwg's approach to staff experience is shared widely with other services. Other health boards model their training and leadership programmes on Cwm Taf Morgannwg's templates. The annual staff survey consistently demonstrates high satisfaction rates.

Revised Maternity Improvement Plan – High Level Timeline




Jan- Mar 2020
Apr – June 2020
July – Sept 2020
Oct – Dec 2020
Jan – Mar 2021
Apr – June 2021
QUALITY OF LEADERSHIP AND MANAGEMENT PROJECT
Staff Health and Wellbeing
Development of Staff Wellbeing Plan to include staff survey and programme to reduce sickness rates.
Sickness rates within range
Ongoing Monitoring
Workforce Planning
Midwifery Staffing Levels
Birthrate+ Compliance
Ongoing Monitoring
Develop longer term recruitment and retention plans
Skilled Workforce
Improve clinical training compliance
Ongoing Monitoring
Use training needs analysis for training planning and improve mandatory training and PDR compliance
Values and Behaviour
Implement Organisational Development Programme and Evaluate Outcomes
Publish evaluation and plans
Ongoing Monitoring
Leadership and Oversight
Appoint new leadership team
Implement leadership and board development training and develop succession planning model
QUALITY OF WOMEN'S AND FAMILIES' EXPERIENCE PROJECT
My Maternity My Way
Recruitment drive to recruit additional lay members
Strengthen the role of MMMW as a monitoring group
Co-Production
Ongoing - Work collaboratively with CHC Colleagues, Women & Families - ongoing engagement through various project board and public engagement events and utilise feedback to inform Quality Improvement Projects
Task and Finish Group to improve experience of women and partners
Engagement
3rd engagement event in Bridgend & themes in action plan
Development of co-produced community engagement plan for 2020– 2023
Publish Plan
Implementation
Listening Into Action
Pilot real time feedback in ante-natal clinics and evaluate
Programme to introduce validated Maternity Patient Reported Experience Measure (PREM) into service
Identifier key:
Key Activity
Completion of Recommendation
Sustaining Improvement
Slippage

Maternity Improvement Plan

Additional Recommendations Recorded as Completed (January – March 2020)

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

During the previous reporting period (October – December 2019), 25 of the 79 recommendations were verified as completed. Details of these recommendations can be found in the Panel's Winter 2019 Quarterly Progress Report published in January 2020. In the current reporting period (January – March 2020), the Panel has assessed supporting evidence provided by the Health Board and agreed that a further 16 actions had been progressed and were ready for 'sign off' as completed. That brings the total number of recommendations now completed as at the end of March 2020 to 41.

It will be note that some of the actions are what might be referred to as 'technical write-offs' based on the fact that they duplicate other actions, or have been superseded by events. For example, the imposition of 'Special Measures' and the development of the Maternity Improvement Programme has made a number of more specific actions no longer relevant.

The remaining 39 actions are all work in progress in varying stages of completion. That includes 3 recommendations which the Health Board felt were delivered but the Panel was unable to agree. Further evidence has been requested and those action will be presented for further assessment in the next period.

In addition to the 16 actions which were verified as completed in this period, 5 further actions which were verified as completed in the previous period were reassessed to ensure that they remain embedded in operational practice and those have been re-validated during this quarter.

Details of the 16 actions which were newly verified as 'signed off' and the 5 actions which have been re-verified are set out in the table overleaf, grouped by the three project workstreams (which align with the three performance domains with the IPAAF). In some cases, the Panel felt that a follow-up check or review was necessary to ensure that the action is embedded in practice and where that is the case, it is indicated in the table. Further checks will be scheduled into the Panel's programme of assurance going forward.

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

PROJECT WORKSTREAM: Safe and Effective Care				
Action Ref:	**Source**	**Recommendation**	**Agreed as Completed**	**Follow-Up Required?**
7.11 **REVIEW**	RCOG	**Mandatory Meetings** - Ensure mandatory attendance at key meetings for all appropriate staff.	Verified 16.12.19 **Re-Verified 18.02.20**	Health Board Determined.
7.14 **REVIEW**	RCOG	**Joint Consultant Meetings** - Regular meeting process to be introduced.	Verified 16.12.19 **Re-Verified 18.02.20**	Health Board Determined.
7.16 **REVIEW**	RCOG	**Obstetric Consultant Availability** - On-call response to be maximum 30 minutes from call to being present.	Verified 16.12.19 **Re-Verified 23.03.20**	Monitored through weekly performance arrangements with exception reporting to Panel.
7.21 **REVIEW**	RCOG	**Incident Reporting** - Improve incident reporting through Datix system for all staff.	Verified 16.12.19 **Re-Verified 18.02.20**	Ongoing monitoring. Health Board to review quarterly and share with Panel.
7.27 **NEW**	RCOG	**Maternity Governance and Risk Team** - Provide additional resources to ensure (i) workload is manageable and (ii) Datix are reviewed, graded and actioned in an appropriate and timely manner.	**Verified 23.03.20**	Ongoing monitoring. Health Board to review quarterly and share with Panel.
7.66 **NEW**	RCOG	**Risk Register** - To be updated and reviewed regularly at Board.	Not Verified 16.12.19 **Verified 09.03.20**	Ongoing monitoring by Health Board.
D.U.1. **NEW**	Delivery Unit	**Use Learning to Inform Improvement** - process to be included within new Governance Arrangements.	**Verified 18.02.20**	6 Monthly Panel follow-up to check fully embedded.

D.U.2. **NEW**	Delivery Unit	**Clinical Review** - Complete the reviews of the 43 incidents in the cluster utilising the RCA methodology and including peer review of the clinical outcomes.	**Verified 18.02.20**	Action written off on the basis that it has been superseded by the Clinical Review Programme.
D.U.3. **NEW**	Delivery Unit	**Governance Processes** - Ensure Maternity Directorate processes are consistent with the Corporate process to ensure appropriate escalation.	**Verified 23.03.20**	6 Month Panel follow-up to check fully embedded.

PROJECT WORKSTREAM: Quality of Leadership and Management				
7.5 **NEW**	RCOG	**CTG Training Programme** - Competency assessment delivered to all staff involved in care of pregnant women (antenatal and intrapartum).	**Verified 18.02.20**	Health Board training cycle due for full completion end of March 2020. 6 Month Panel follow-up to confirm fully embedded.
7.6 **REVIEW**	RCOG	**Consultant Standard Induction Programme** - Obstetrics and Gynaecology Consultant staff must deliver (i) a standard induction programme for all new junior medical staff, and (ii) a standard induction programme for all locum doctors.	Verified 16.12.19 **Re-verified 18.02.20**	6 Month Panel follow-up to check post-August inductions.
7.13 **NEW**	RCOG	**Clinical Lead for Governance** - Identify lead consultant (i) accountable for good governance and (ii) attends governance meetings ensuring leadership and engagement.	**Verified 18.02.20**	Health Board Determined.
7.24 **NEW**	RCOG	**Multidisciplinary Working** - Identified clinical lead from senior medical staff within the directorate to support the current midwifery governance lead.	**Verified 18.02.20**	Health Board Determined.

7.33 **NEW**	RCOG	**Training Environment** - Actively share findings of RCOG review with Welsh Deanery and urgently encourage them to revisit the Health Board to (i) reassess quality of induction, training and supervision in obstetrics, (ii) seek assurance on suitability of service for trainees, and (iii) appoint named RCOG College tutor to support trainees on the RGH site.	**Verified 18.02.20**	Health Board Determined.
7.41 **NEW**	RCOG	**Planned Merger** - Consider Impact of Planned Merger of consultant lead units at PCH and RGN on culture.	**Verified 18.02.20**	Action written off. Merger occurred over 12 months ago and culture is being addressed through a range of other actions.
7.43 **NEW**	RCOG	**Planned Merger** - Undertake in-depth assessment of service as it moves into future with new ways of working and potential increased service demand. This can determine structures and competencies of clinical leadership and governance that will support the service.	**Verified 18.02.20**	Action written off. Merger occurred over 12 months ago. New structures have been implemented. Longer term action is being addressed elsewhere within the improvement plan.
7.58 **NEW**	RCOG	**Strategic Development** - Seek expert external midwifery and obstetric advice for support in developing maternity strategy and use the opportunity to explore new ways of working.	**Verified 23.03.20**	Action written off on the basis that it has been superseded by the special measures arrangements and Maternity Improvement Programme.
7.64 **NEW**	RCOG	**Board Awareness** - Independent Board Members to be trained in implications of Corporate Manslaughter and Corporate Homicide Act 2007 to better understand their role in ensuring the safety of services provided by Board.	**Verified 10.03.20**	Health Board Determined.

PROJECT WORKSTREAM: Quality of Women's and Families' Experience				
7.50 **NEW**	RCOG	**Community Engagement** - Continue to work with the MSLC (now 'My Maternity, My Way') to build on community-based engagement approach being suggested.	**Verified 26.03.20**	Lay Member actively involved in ongoing development of next steps plan.
7.55 **NEW**	RCOG	**Bereavement Service** - Review the level and effectiveness of the service and (i) ensure appropriate support & counselling available for families as required, and (ii) consider implementing National Bereavement Care Pathway developed by SANDS in collaboration with stakeholders including women and their families, RCOG and RCM.	**Verified 23.03.20**	Health Board Determined (Further development work currently being undertaken by MMMW Task and Finish Group).

Y PANEL TROSOLWG ANNIBYNNOL AR WASANAETHAU MAMOLAETH
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg

INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL
Cwm Taf Morgannwg University Health Board

Independent Maternity Services Oversight Panel

Position Statement – COVID-19

In response to the developing COVID-19 situation, the Independent Maternity Services Oversight Panel has reviewed its working practices based on the need to:-

1. take account of Government guidance, including restrictions on travel and advice about work-related contact;
2. optimise patient safety, including minimising the risk of virus transmission caused by the Panel's activities;
3. ensure the welfare of the Panel and its key stakeholders, including the Health Board staff and Welsh Government officials;
4. reduce the burden of the Panel's activities on the Heath Board at a time when healthcare services are under considerable pressure.

Taking account of those four key principles, the Panel believes that its oversight and scrutiny work remains vital to the provision of safe, high quality maternity services within Cwm Taf Morgannwg University Health Board and has concluded that the focus and momentum which it is providing to the improvement process should be maintained. That includes the need to identify and act upon the learning which is emerging from the Panel's Clinical Review Programme and to engage effectively with the women and families affected.

It is also important that weekly Welsh Government arrangements which monitor staffing, clinical activity and outcomes are maintained and continue to feed into the Panel's work.

However, in light of the current situation, for the next few weeks, the Panel will adopt a proportionate, risk-based approach to its work and will make adjustments to its working practices based on the four principles set out above and the advice of Welsh Government and the Health Board's Senior Responsible Officer.

The Panel's immediate actions will include minimising unnecessary travel and optimising remote working capabilities. Alternative ways of information sharing will be identified, including live blogging and online seminar/workshop style approaches.

The Panel will review its working arrangements on a weekly basis, giving careful consideration to the continually changing landscape and requirements of NHS frontline services to maintain a state of readiness.

This is a challenging time for the whole NHS family and it is essential that the quality and safety of care for mothers, babies and families is maintained.

11 GLOSSARY OF TERMS

AM	Assembly Member
AMU	Alongside midwifery led unit
Badgernet	Neonatal patient data management system
BR+	Birthrate plus
CD	Clinical Director
CEO	Chief Executive Officer
CHC	Community Health Council
CMB	Clinical board meeting
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COO	Chief Operating Officer
CPD	Continual professional development
CSfM	Clinical supervisors for midwives
CSR	Caesarean section rates
CTG	Cardiotocography
CTMUHB	Cwm Taf Morgannwg University Health Board
CTUHB	Cwm Taf University Health Board
Datix	Patient safety software
DON	Director of Nursing
DU	NHS Wales Delivery Unit
EBC	Each Baby Counts
ELCS	Elective caesarean section
EMCS	Emergency caesarean section
Euroking	National maternity IT system
GAP	Growth assessment protocol
Greatix	Initiative based on ‘Datix’ for reporting positive feedback to staff
GROW	Gestation related optimal weight
HB	Health Board

HEIW	Health Education & Improvement Wales
HIE	Hypoxic ischaemic encephalopathy
HIW	Healthcare Inspectorate Wales
HOM	Head of Midwifery
HOMAG	The All Wales Heads of Midwifery Advisory Group
HR	Human resources
HSCSC	Health, Social Care & Sport Committee
HTA	Human Tissue Authority
ICU	Intensive Care Unit
IMSOP	Independent Maternity Services Oversight Panel
IOL	Induction of labour
IPAAF	Integrated Performance Assessment and Assurance Framework
KPI	Key performance indicators
LA	Local Authority
LNU	Local neonatal unit
LSA MO	Local supervising authority midwifery officer
LSCS	Lower segment caesarean section
MBRRACE	Mothers and babies: Reducing risk through audits and confidential enquiries
MDT	Multidisciplinary team
MDT	Multidisciplinary team
MHSS	Minister for Health and Social Services
MIB	Maternity Improvement Board
MID	Maternity Improvement Director
MIP	Maternity Improvement Plan
MITs	Maternity Information Technology System (feeds into QlikSense)
MLC	Midwifery led care
MLU	Midwifery led unit
MPB	Maternity performance board
MSLC	Maternity Services Liaison Committee
MVF	Maternity Voices Forum

NEWTT	Neonatal early warning track and trigger
NICU	Neonatal intensive care unit
NMPA	National Maternity and Perinatal Audit
NNAP	National Neonatal Audit Programme
O&G	Obstetrics and gynaecology
OD	Organisational development
PADR	Personal appraisal and development review
PALS	Patient Advice and Liaison Service
PCH	Prince Charles Hospital
PDM	Practice development midwife
POW	Princess of Wales Hospital
PSAG	Patient status at a glance
PSOW	Public Service Ombudsman for Wales
PTR	Putting Things Right
Q&S	Quality and safety
QA	Quality assurance
QlikSense	Business intelligence and visual analytic software
QSR	Quality, Safety & Risk
RCA	Root cause analysis
RCA	Royal College of Anaesthetists
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics & Child Health
RGH	Royal Glamorgan Hospital
SB	Stillbirth
SBAR	Acronym for stillbirth, background, assessment and response
SCBU	Special care baby unit
SCU	Special care unit
SFH	Symphysis fundal height
SGA	Small for gestational age
SI	Serious incident

SM	Special Measures
SMART	Acronym for Specific, Measurable, Achievable, Relevant and Time-Based
SOM	Supervisor of midwives
SRO	Senior Responsible Officer
SUI	Serious unreported incident
SWP	South Wales Plan
TI	Targeted Intervention
Trac	A large UK database of 'jobs boards' for health and public sector
UHB	University Health Board
USS	Ultrasound scan
WAO	Wales Audit Office
WG	Welsh Government
WRP	Welsh Risk Pool

N.B. This is a generic glossary which covers terms which have been or may in the future be used in the Panel's reports. Not all of the terms will necessarily have been used in this particular report.