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# QUALITY & SAFETY COMMITTEE

## RESPONSE TO NHS DELIVERY UNIT ASSURANCE REVIEW OF OPEN INCIDENTS WITHIN MATERNITY & NEONATAL SERVICES

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| **Date of meeting** | (22/09/2021) |
| **FOI Status** | Open/Public |
| **If closed please indicate reason** | Not Applicable - Public Report |
| **Prepared by** | Louise Mann, Assistant Director, Quality Safety & Safeguarding |
| **Presented by** | Louise Mann, Assistant Director, Quality Safety & Safeguarding |
| **Approving Executive Sponsor** | Executive Director of Nursing |
| **Report purpose** | FOR DISCUSSION / REVIEW |

| **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)** | | |
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| **Committee/Group/Individuals** | **Date** | **Outcome** |
| (Insert Name) | (DD/MM/YYYY) | Choose an item. |

| **ACRONYMS** | |
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| | All explained within the report |

## 1. SITUATION/BACKGROUND

This paper offers assurance that the significant number of open serious incidents within maternity and neonatal services at Cwm Taf Morgannwg Health Board are being identified, prioritised and robustly progressed through to closure at pace. This includes ensuring comprehensive investigation, learning, action planning and quality assurance takes place, as well as compassionate consideration of the families involved, redress and Putting Things Right Legislation (PTR).

It has been agreed that the NHS Delivery Unit (DU) will support the Health Board in achieving the outstanding areas of improvement needed within the overall investigation process. This will also align with the wider DU intervention in respect of the corporate approach to the management of incidents and concerns following the DU review in 2019. It is very important that the health board assimilate maternity and neonatal services within its organisational strategic and operational core business in respect of quality, patient safety and experience.

This work commenced in May 2021 led by the Assistant Director of Quality, Safety and Safeguarding and the corporate patient safety team, working jointly with the Director of Midwifery, maternity and neonatal colleagues. The DU findings report ***CTMUHB Maternity and Neonatal Services Serious Incidents Assurance Review, NHS Delivery Unit, (August 2021)*** has been submitted to the chair of the IMSOP Board to inform them of progress thus far.

This report articulates the current position of the Health Board in relation to the DU findings and recommendations in their report. The findings articulated that the Health Board demonstrated strong leadership, engagement and a determination to put things right. Noting in particular, that the Central Team involvement has had a significant impact, on supporting the Maternity and Neonatal services, to improving the quality of incident management. The Maternity and Neonatal services are viewed by the DU as being well placed to build on the actions and the improvements identified in the report, illustrating the potential to develop the current approach to that of exemplar status.

## 2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING

### NHS Delivery Unit Recommendations, August 2021

| Recommendation 1 |
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| *The Health Board undertakes a capacity assessment of Maternity and Neonatal services, to ensure there is sufficient capacity and skills to manage incidents, including incident reporting, proportionate investigations, sharing of learning, and the implementation of corrective actions. The assessment should be factored against average incident reporting numbers over the past 12 months, and in keeping with requirements of the national incident reporting Framework.* |
| Both services welcome an opportunity to review the structures, skills and resources relating to incident management and subsequently to preventing recurrence of harm.<br><br>Maternity services have reviewed and refreshed systems and process for identifying reporting and managing incidents, and have implemented agreed methodologies for shared learning. The review will be completed by 31st October and be shared at the Maternity and Neonatal Improvement Board in November 2021.<br><br>The Neonatal element of the improvement team requires additional support and resource to continue progress as the current pace is increasingly challenged. As such, a request for support has been escalated within the UHB and a Band 7 patient safety manager from within the central team has been allocated. All opportunities are being used to redesign and enhance roles with some additional resourcing costed and under consideration. |

| **Recommendation 2** |
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| *The Health Board develops a Quality Assurance Framework for Maternity and Neonatal services. The Framework should support consistency in the* |

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| *effective governance of quality and safety matters across the clinical support groups, ensuring integration with Locality Groups and central (Corporate) functions. The Framework will clearly define accountability of the Integrated Locality Groups (ILG) and the corporate responsibilities of the Director of Midwifery and Director of Neonatal Services.* |
| Maternity Services has recently been integrated into the ILG structure, which has led to a change to both reporting and assurance. The Health Board also supported implementation of the Royal College of Midwifery Leadership structure. This meant the appointment of a Head of Midwifery for Bridgend and Merthyr Cynon ILG's whilst the Director of Midwifery continued a dual role to support the maternity improvement programme, and the oversight of the Health Board's response to the external review of maternity cases. This structure has strengthened accountability and responsibility in respect of assurance and operational oversight.<br><br>The Health Board has recently confirmed its intention to make a permanent commitment to this strengthened structure and as a result, the Maternity Assurance Framework is under review with support of the DU. The framework will be presented for consultation with executive, ILG and central team colleagues by the 31st October 2021 |

| **Recommendation 3** |
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| *The Delivery Unit continues to monitor and provide independent quality assurance to the Serious Incident closure forms until the Service is out of special measures.* |
| The Health Board has welcomed the intervention of the DU in supporting the progression of good quality assurance of its open maternity and neonatal investigations. This provides the Health Board with independent |

scrutiny and appropriate challenge to its processes with a focus on quality and learning.

The Maternity & Neonatal Assurance and Closure panels are in place and operate on a fortnightly basis where an average of 7 cases are heard. Operational pressures such as sickness absence and covid, have impacted on more recent panels and the availability of colleagues to bring cases to panel has been a challenge. It remains clear however that there is continued commitment to the panels and good medical, nursing and midwifery representation has been maintained. Progressing cases presented at panel to closure has remained slow and measures have now been introduced to make the process leaner with an extra resource provided to support the co-ordination of the panel, case preparation and closure.

**Current status**

Open Maternity/neonatal cases:105

Cases agreed closure at panel: 7

Cases pending closure following panel (minor remedial work): 9

Cases requiring resubmission to panel: 10

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| **PANEL A 30/07/21** | **7 cases** |
| **PANEL B 13/08/21** | **8 cases** |
| **PANEL C 23/08/21** | **8 cases** |
| **PANEL D 07/09/21** | **3 cases** |

3 Learning Events have been held in relation to thematic findings from the risk stratification of this work with excellent feedback from practitioners and external observers. Future learning events will focus on

Human Tissue Authority, Therapeutic Cooling, and Safeguarding & Procedural Response to Unexpected Deaths in Childhood processes.

Panels will continue until all cases have been closed, however this model will be recommended to continue as a vehicle for robust assurance in respect of current case management.

A Showcase event to demonstrate the journey travelled in relation to this process is planned for October 2021.

| **Recommendation 4** |
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| *A mentorship system is developed to support new investigators during their first investigations. Consideration should be given to the benefits of a peer support group, which incorporates clinical supervision for investigator's, recognising the emotional resilience required to undertake this area of work*. |
| The Health Board recognises that new investigators and those who undertake this work infrequently require additional guidance, advice and support. The ILG governance teams are available to provide this support and supervision directly to their clinical service groups and hosted services. In addition the central patient safety team is about to launch a 6 weekly Patient Safety Clinic (on world patient safety day 17/09/21); a webinar opportunity to share learning in relation to incidents, showcasing new ideas and developments in patient safety, and provide a regular point of access for expert advice and support with individual cases. |

| **Recommendation 5** |
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| *To support a healthy Organisational reporting culture, and following the adoption of the new Once for Wales Datix Incident management module,* |

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| *the Health Board should mandate that the outcomes field is completed with identified learning and actions prior to the closure of incidents, so that meaningful feedback is given automatically to the reporter upon closure.* |
| The Health Board can only develop certainty in its positive reporting culture when accurately benchmarked against another similar organisation on a similar range of incidents. The DU intervention will support the Health Board's understanding of reasonable comparison.<br>Within the Health Board's existing DatixWeb, the process involves the automatic sending of an email notification to the reporter on the incident being moved to the final approval stage by the responsible manager. The email notification contains information directly from the feedback to reporter of *what action was taken* field within the investigation screen of the RLDatix system. This feature was activated on the 01/10/19 and applied to all incidents reported after this date.<br><br>When an incident has moved to *Investigation Completed* the feedback to the reporter of what action was taken field will appear and become mandatory. This means that before the record can be saved in that status the feedback field will have to be completed. This will also ensure that when the responsible manager moves the incident to final approval the field will have been previously completed and the reporter will receive feedback. This has been in place since the 01/12/20.<br><br>The mandating of fields within the new Once for Wales System is determined by the National Workstream. The Health Board have made a request regarding the mandating of fields, as testing of the system has determined that records can be closed without a number of key fields such as feedback being completed. The Health Board has delayed the |

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| implementation of the Incident Management Module due to concerns in relation to its current functionality until 2022. |

| **Recommendation 6** |
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| *To support a just Organisational culture around the reporting and investigation of incidents, the Health Board should ensure investigators focus learning and actions, where applicable, to a more systems analysis approach, rather than focusing findings and actions to individuals involved in incidents. A 'Just Culture' should continue to be embedded in the Organisation through the existing focus on the Organisation's new values.* |
| Following the DU's 2019 recommendations in relation to incident management, there have been a number of changes to improve the quality of investigations, including the roll out of regular RCA training and a revised incident investigation toolkit and quality assurance of every report prior to executive sign off. Governance in relation to investigation of incidents has strengthened with the implementation of the organisation's regional operating model and central oversight. This has had a positive impact on the quality of investigations. The DU's changes to incident reporting and proportionate investigation has facilitated a move toward a more systems based approach to incident investigation and learning, with a shift from a punitive focus on individuals, however this will need support through training and embedding a cultural change in Organisational thinking; the expansion of safety II methodology and practice supported by the CTM Values and Behaviours. |

| **Recommendation 7** |
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| *The Health Board should review and update the central policy for the management and investigation of incidents to align with recently updated* |

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| *national incident reporting policy, and NHS Wales implementation guide published by the Delivery Unit.* |
| The central patient safety team are currently revising the incident management policy, an associated incident management toolkit and a new Quality Assurance checklist in line with the new national reporting requirements. We have also introduced a Locally Reportable Incident system, which ensures that the organisation continues to track, audit and provide assurance of robust investigation from service to board on all significant incidents where harm has occurred.<br>Anticipated date of completion: October 2021 |

## 3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

The Health Board is committed to quality and patient safety particularly in relation to the effectiveness of its health services, the safety of its health services, and the experience of individuals to whom our health services are provided [Health and Social Care (Quality and Engagement) (Wales) Act 2020]. The Health Board is grateful to the Delivery Unit for providing support in relation to open incident management within its maternity and neonatal services.

There are some risks associated with the intensity of the work described within the report. This is mainly in relation to the continued threat of the covid third wave and its impact on colleague availability should a pandemic workforce response be required. In addition, the recent public announcement of the concerns in relation to the neonatal services at Prince Charles Hospital has impacted upon colleague's ability to maintain the pace of the assurance work whilst managing operational pressures and urgent improvement work. Any impact will be monitored and communicated via the weekly DU assurance meetings.

## 4. RECOMMENDATION

- **NOTE** this report; the operationalisation of the NHS Delivery Unit supportive assurance review and progress in relation to its findings and recommendations.
- **Note** that weekly reporting of progress of the assurance work takes place to the executive team and led by the Executive Nurse Director.