AGENDA ITEM
6.1.1

QUALITY & SAFETY COMMITTEE

NHS DELIVERY UNIT/CTMUHB ASSURANCE REVIEW OF OPEN INCIDENTS WITHIN MATERNITY & NEONATAL SERVICES

Date of meeting	22/03/2022
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)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
	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 have been identified, prioritised and robustly progressed through to closure. 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). One of the overarching aims of the IMSOP Clinical Review Strategy includes *"the quality assurance of SI investigations that have occurred post 1st October 2018 is completed in order to validate the current ways of working as fit for purpose going forward".*

A number of the maternity and neonatal SI's that have been reported to Welsh Government (WG) since the 1st of October 2018 have been reviewed by an independent review team as part of the IMSOP process. The review team found a number of concerns and made recommendations in relation to the quality of the investigations. A number of historic incidents were identified as requiring further review and assurance. Detailed SBAR (Situation, Background, Assessment, Recommendations) communications were provided to the Health Board outlining the improvements required. These included recommendations and improvements in relation to serious incident reporting, timely investigation and robust assurance processes, specifically:

- **Datix, incident & RCA investigation training.**
- **Multidisciplinary & collaborative working.**
- **Feedback, sharing learning from incidents & embedding into practice.**
- **Leadership, culture, governance & escalation processes.**

The Welsh Government and IMSOP commissioned the NHS Delivery Unit (DU) to lead a supportive assurance assessment of the Health Board's maternity and neonatal services in being able to meet the identified recommendations, and in particular the specific points highlighted within the SBARS. This in turn, would inform the evidence review process to be undertaken by IMSOP to enable them to discharge their terms of reference.

The NHS Wales Delivery Unit were tasked to:

1. Support the Health Board in managing their incident assurance process for progressing the identified outstanding serious incidents to closure and in doing so will address the process improvements required as identified by IMSOP.

2. Support the Health Board maternity and neonatal services to systemise their incident assurance process from the directorate through to board in line with the requirements of the HB's policy and procedures and the new Welsh Government national incident policy.

This work commenced in May 2021 led by the Assistant Director of Quality, Safety & Safeguarding and the corporate patient safety team, working jointly with maternity and neonatal colleagues. There were a total of 72 historical incidents to progress through to closure. The timeliness of the work has been impacted upon by covid pandemics, redeployment, parallel reviews and business continuity requirements, however excellent health board colleague commitment and progress has been made throughout this time.

The DU findings report *CTMUHB Maternity and Neonatal Services Serious Incidents Assurance Review, NHS Delivery Unit, (August 2021)* was submitted to the chair of the IMSOP Board to inform them of positive progress in relation to this work, and periodic updates to this committee, and the Maternity & Neonatal Improvement Board have been made. This report is submitted in anticipation of the completion of this work stream with particular reference to the DU August 2021 findings (Appendix 1).

The way in which this work has been operationalised and progressed within the health board is described within this report.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING

- **Operationalising the work within the UHB**

The corporate team have been responsible for the coordination of the historical Serious Incident (SI) review and closure work, collaborating closely with maternity and neonatal service leads, in addition to responsible ILG governance teams. A patient safety practitioner from the central team has been allocated to co-ordinate the management of the SI's through to closure, support clinical colleagues with investigations, including providing bespoke Root Cause Analysis (RCA) training. Weekly meetings with the DU and key health board representation have been maintained to support engagement, pace and any troubleshooting within the work. The DU as part of their general assurance review have engaged in meetings with the ILG Heads of Quality and Safety in relation to organisational incident management and governance.

- **STAGE 1 Reconciled Database of open incidents – information in one place**

✓ An agreed, inclusive database of open incidents within maternity and neonatal services from October 2018 was established.

- ✓ Risk stratification and analysis of the maternity & neonatal incident data with trajectory for completion date.
- ✓ 72 historical incidents to be reviewed, investigated and closed.
- ✓ The database is overseen and updated by the corporate team on a weekly basis and is the only validated record of the status of all open incidents within maternity and neonatal services.
- ✓ New incidents that meet the threshold for National Reporting are added to the database as to ensure timely 'business as usual' case management is maintained.

- **STAGE 2 Multi-disciplinary Closure & Assurance Panels**

- ✓ Multi-disciplinary Closure and Assurance Panels have been set up by the central team to convene on a fortnightly basis to consider between 6-10 completed incidents from the database for closure, quality assurance and consideration of further action.
- ✓ Central patient safety practitioner co-ordinator assigned from the central team.
- ✓ The panels have clear terms of reference, membership quoracy from the central team, maternity, neonatal, paediatrics, legal representation and Delivery Unit colleagues.
- ✓ Panels provide high-level scrutiny, case independence, challenge and Quality Assurance.
- ✓ Panels have facilitated peer learning & sharing, improved investigations, relationship building, engagement and culture change.
- ✓ Fifteen panels have been held in total to complete the work.

- **STAGE 3 Learning Events**

- ✓ Themes have been clustered to provide an economic, effective use of panels for assurance & support learning.
- ✓ Internal and external stakeholder attendance.
- ✓ Learning made available to a broader audience and captured within a seven minute briefing to share widely with via the Shared Listening and Learning Forum and externally as appropriate.
- ✓ Three learning events have been held in August 2021 in relation to joint themes within both maternity and neonatal.

- **Next steps**

- ✓ Thematic consolidation of the learning from historical Serious Incidents, ensuring integration of service specific and organisational recommendations and action plans
- ✓ Family contact, redress & Putting Things Right panels for relevant cases

- ✓ Safety II approach, human factors training, investigation & incident management training and improved central support with patient safety issues.
- ✓ Quality Assurance, Escalation and Risk Framework for Maternity and Neonatal services to build on current strong collaborative working and alignment with CTMUHB Quality and Patient Safety Governance (Appendix 1).
- ✓ Incident management framework and toolkit in line with new National Reporting (planned to be launched when the health board goes live with the Once for Wales incident module in April 2022).
- ✓ Listening & Learning Framework & Forum (Appendix 1).
- ✓ Future learning events planned on common themes.
- ✓ Promotion of Closure and Quality Assurance panels as a good practice model for all health board incident assurance and closure. This model is now being adopted within other clinical service groups and promoted by ILG governance teams. The model can be shared with other organisations as an exemplar of good practice.

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.

This approach has achieved the completion of an important task in respect of ensuring robust investigations have taken place on historical serious incidents, in order to provide colleagues, individuals and families with resolutions. The process has also facilitated significant wider improvements in the quality of incident management and investigation and responded to the specific recommendations of IMSOP:

- ✓ Improved organisational Quality Assurance process.
- ✓ Panels providing safe challenge by multiple staff from clinical, governance, legal and central teams
- ✓ Robust quality assurance checklist has underpinned understanding of 'what good looks like' resulting in improved syntax, grammar and appearance.
- ✓ Clearer links between care and service delivery issue, recommendations and actions with evidence of completed actions.
- ✓ Closer working between corporate, maternity and neonatal teams.
- ✓ Alignment with organisational quality governance processes.
- ✓ Clinical teams understanding, confidence and expertise has grown resulting in wider staff engagement

A compassionate focus on individuals and families affected by the incidents will also be maintained and supported by the corporate concerns team, with particular consideration to family contact, redress and Putting Things Right regulations. This work has begun however it is recognised that significant resource will be required from clinical and corporate services to facilitate this work in a sensitive, timely manner.

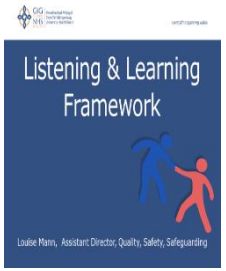
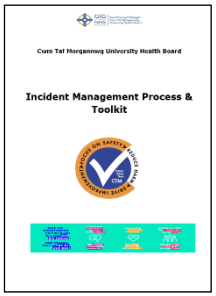
4. IMPACT ASSESSMENT

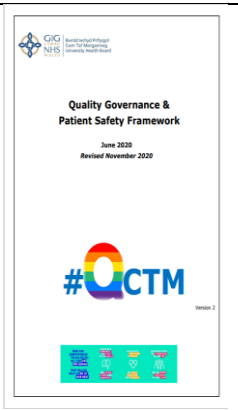
Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Safe Care
	Governance, Leadership & Accountability
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	No EIA implications
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

- **NOTE** this report; the operationalisation of the NHS Delivery Unit supportive assurance review and health board progress in relation to resolution of historical open incidents within maternity and neonatal services.

Appendix 1 (attached)

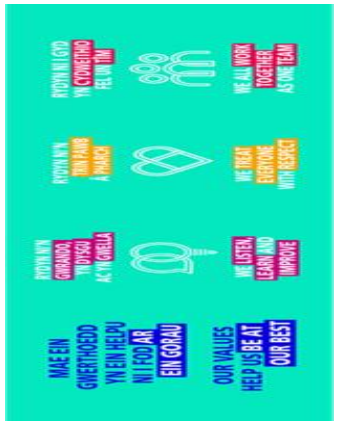
Recommendation 1	JUNE 21 2021	AUGUST 21	MARCH 22	EVIDENCE	RAG STATUS
The Health Board undertakes a capacity assessment of Maternity and Neonatal services, to ensure there is sufficient capacity and skills to manage incidents, including incident reporting, proportionate investigations, sharing of learning, 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 welcomed an opportunity to review the structures, skills and resources relating to incident management and subsequently to preventing recurrence of harm. Maternity services have reviewed and refreshed systems and process for identifying reporting and managing incidents in line with new National and Local reporting requirements and have implemented agreed methods of shared learning. The review was shared at the Maternity and Neonatal Improvement Board in November 2021.	Historical open Serious Incidents have been progressed through the formation of Quality Assurance and Closure panels. The panels are multi-disciplinary with senior clinical representation from maternity, neonatal and paediatric teams in addition to the central governance team and NHS Delivery Unit colleagues. Panel & Assurance Co-ordinator assigned from the central team. The panels have clear terms of reference, membership quoracy from the central team, maternity, neonatal, paediatrics, legal representation and Delivery Unit colleagues.	Panels have facilitated peer learning & sharing, improved investigations, relationship building, engagement and culture change. Panels provide high-level scrutiny, case independence, challenge and Quality Assurance. Fifteen panels have been held in total to complete the work. Panels will continue to use to scrutinise all maternity and neonatal incident investigations.	 	
Recommendation 2					
The Health Board develops a Quality Assurance Framework for Maternity and Neonatal services. The Framework should support consistency in the effective governance of quality and safety matters	Maternity Services has recently been integrated into the ILG structure, which has led to a change to both reporting and assurance. The	The Health Board has recently confirmed its intention to make a permanent commitment to this strengthened structure	Maternity & Neonatal, Assurance, Risk & Escalation Framework presented for executive approval.		

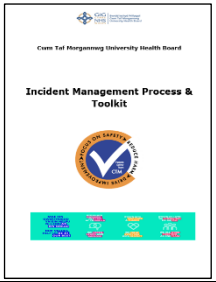
across the clinical support groups, ensuring integration with Locality Groups and central (Corporate) functions. The Framework will clearly define accountability of the Integrated Locality Groups (ILG) and the corporate responsibilities of the Director of Midwifery and Director of Neonatal Services.	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.	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					
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	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 affected more	All historical maternity/neonatal Serious Incident cases have progressed through to investigation, panel assurance and been submitted to the DU.		

	processes with a focus on quality and learning.	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. 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	A Stakeholder Showcase Event was held in November 21. Working together we have: Improved organisational QA process. Panels providing safe challenge by multiple staff from clinical, governance, legal and central staff Robust quality assurance checklist has underpinned understanding of 'what good looks like' resulting in improved syntax, grammar and appearance. Clearer links between care and service delivery issue, recommendations and actions with evidence of completed actions.		

		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.	Closer working between corporate, maternity and neonatal teams Clinical teams understanding, confidence and expertise has grown resulting in wider staff engagement		
Recommendation 4					
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 investigators, 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	The corporate team continue to support maternity and neonatal services and provide bespoke investigation training. Rapid meetings, assurance panels and feedback events/ meetings have facilitated improved support and feedback for those involved in incident	Patient Safety Clinics to commence in April 22 to provide peer support, advice and information - with a focus on Human Factors, Psychological Safety and Safety II. These are particular themes emerging from the historical mat/nn reviews. Incident management toolkit is in draft and		

	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.	management and investigation. 'Approved' investigators are recognised on ESR and RCA's can only be completed by an investigator who has received HB training. All staff currently have access to the 'Assist Me' package and organisational wellbeing support.	awaiting executive sign off. Feedback on improved processes have been sought from maternity and neonatal colleagues. Assistant Director exploring the TRiM model of supporting colleagues involved in incidents, incident management and investigation to provide high quality mechanism to promote resilience, Just Culture, and well-being.		
Recommendation 5					
To support a healthy Organisational reporting culture, and following the adoption of the new Once for Wales Datix Incident management module, 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.	Improvements to meaningful feedback from incidents within maternity are being trialed through group feedback meetings.	CTMUHB will adopt the Once for Wales Incident Management Module on April 1st 2022. Incident Management toolkit awaiting executive approval.		

	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.				
Recommendation 6					
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 role out of regular RCA training and a revised incident investigation toolkit and quality assurance of every report prior to executive sign off.	National 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. This will need support through training and embedding a cultural change in	Establishment of #SafetyCTM – a dedicated resource to promoting patient safety throughout the organisation. Patient Safety Clinics to commence in April 22 to provide peer support, advice and information - with a focus on Human		

	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.	organisational thinking; the expansion of safety II methodology and practice supported by the CTM Values and Behaviours.	Factors, Psychological Safety and Safety II. These are particular themes emerging from the historical mat/nn reviews. Incident management toolkit is in draft and awaiting executive sign off. Assistant Director exploring the TRiM model of supporting colleagues involved in incidents, incident management and investigation to provide high quality mechanism to promote resilience, Just Culture, and well-being.	 	
Recommendation 7					
The Health Board should review and update the central policy for the management and investigation of incidents to align with recently updated 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	New guidance issued within the health board to consolidate the reporting of incidents that no longer meet the criteria for National reporting (NRI's) and those that previously met the criteria for Serious	CTMUHB will adopt the Once for Wales Incident Management Module on April 1st 2022. A proportionate Investigation tool with QA checklist is agreed		

	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 were harm has occurred.	Incident reporting, known as Locally Reportable Incidents (LRI's). This is ensure that there remains a consistent, proportionate approach to incident management and investigation, as well as central oversight and monitoring of significant incidents within the footprint of the organisation.	and launched within the HB to ensure robust investigation of moderate harm incidents. Incident Management toolkit awaiting executive approval.