AGENDA ITEM
6.1.2

QUALITY & SAFETY COMMITTEE

NEONATAL DEEP DIVE REVIEW UPDATE

Date of meeting	22/03/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
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Presented by	Dr Sallie Davies, Deputy Medical Director and SRO
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

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	
IMSOP	Independent Maternity Services Oversight Panel
CTMUHB	Cwm Taf Morgannwg University Health Board
MNAF	Maternity and Neonates Assurance Framework
GMC	General Medical Council
NMC	Nursing and Midwifery Council
AMaT	Clinical Assurance Audit Technology
PID	Project Initiation Document

RCOG	Royal College of Obstetricians and Gynaecologists
PCH	Prince Charles Hospital
ATAIN	Avoiding Term Admissions into Neonatal Units

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to update the committee following the IMSOP Neonatal Deep Dive Review of Neonatal Services at Prince Charles Hospital which was published on the 10th February 2022, their findings and the CTMUHB response to date.

In 2020 the Health Board requested an external review of its Neonatal services at Prince Charles Hospital (PCH) as part of the assurance processes being undertaken by IMSOP for Maternity services.

A Neonatal deep dive commenced in May 2021 and in August 2021 IMSOP escalated a number of immediate concerns. These were the subject of a previous paper to the committee, however, these concerns are also contained within the final Neonatal Deep Dive report. The report is available at: https://gov.wales/independent-review-neonatal-services-prince-charles-hospital

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The IMSOP Deep Dive Review report incorporated 42 recommendations for the Health Board and with others for the wider Network. The report was structured into 7 themes: Family Engagement, Governance, Assurance and Accountability, Neonatal Service Workforce, National and Wales Reporting, Neonatal Unit Functionality, Neonatal Unit Safety and Clinical Case Assessment.

The following summarises the concerns within the themes, the progress made to date and the ongoing improvement programme of work

2.2 **Family Engagement**

The panels concerns included family and carer engagement and communication, information shared with families, the involvement of families and carers in their babies care, breastfeeding support and discharge arrangements.

A Family engagement strategy has been drafted and encompasses the required approaches to delivering family centred care through recognised Family Integrated Care (FIC) approaches. A Lead Neonatal Engagement Lead Nurse is due to be appointed who will progress this programme of work.

In addition, a Clinical Psychologist has commenced 2 sessions a week to support families and pilot different approaches.

The Health Boards Infant Feeding Group has recommenced, will refresh its approaches to this agenda and will be required to report into the Starting Well Strategy group.

2.3 **Governance, Assurance and Accountability**

The panel found that the systems and processes currently in place were not clear and did not enable the identification of and learning from events. Clinical Audit was also found to be in need of a more robust approach.

To ensure the most effective robust learning and sharing of excellence a Neonatologist has been appointed to lead the governance agenda and is chairing a refreshed Neonatal Forum. Approaches are under development to ensure that there are clear mechanisms for ward to Board reporting. This also includes the Maternity and Neonatal Assurance Framework; in development with support from the Patient Care and Safety team.

2.4 **Neonatal Workforce**

The panel expressed concerns regarding the consultant cover on the unit, the nursing workforce model, supernumerary roles and the availability of therapies staff. None of which align with national standards.

The development of a sustainable workforce aligned with a Neonatal strategy and vision are to be progressed through a series of workshops. However the following has been progressed to address the immediate concerns:

The Health Board has recently recruited additional consultants and changed job plans to ensure that there is Unit cover 8.30am to 4.30pm each day, with less consultants involved in unit cover; aiding the development of Neonatal expertise.

An interim senior nurse has been appointed purely for Neonates with an improvement arm incorporated within the role to provide more focused senior nursing support and leadership.

A Nurse rotation programme as developed in collaboration with the University Hospital of Wales is planned to commence on a pilot basis with volunteers from the Unit during March

To ensure staff are effectively supported, a model of Clinical Supervision has also been developed with a view to implementing this over the next months for all staff.

2.5 **National and Wales Reporting**

It was highlighted that the Health Board were not using available neonatal data to inform practice, data was poor and there was no systematic way of collating and reporting data.

A Neonatal Dashboard was developed in 2021 with the appointment of a data officer and work has progressed to improve data quality and data analysis. A newly formed Neonatal Data and Performance Forum has commenced with recent support and engagement from the IMSOP panel.

2.6 **Neonatal Unit Functionality**

IMSOP expressed concerns that Maternity and Neonates were not working together as closely as they could, highlighting, for example, issues of joint governance and assurance

Many areas of improvement have been initiated to impact positively on closer working relations between Neonates and Maternity, for example, a joint Maternity and Neonates Audit programme has been developed for 2022, and a joint improvement workstream has been developed, which focuses on the clinical issues identified in the report including ATAIN and transitional care.

2.7 **Neonatal Unit Safety**

Learning from incidents and reflective practice linked to learning were identified as an area for improvement, as was the need to understand and foster a stronger safety culture across the unit.

Progress has been made in the identification and processing of incidents, and as previously reported there is work to strengthen learning and develop a more positive safety orientated culture.

2.8 **Clinical Case Assessments**

The clinical assessments, that underpin the Deep Dive process, identify a number of key escalations that IMSOP are seeking rapid progress on; relating to support for unit doctors from tertiary neonatal services, prescribing standards, management of conditions in line with best practice, assessment and reporting of radiology images, documentation and unplanned extubations.

2.9 The majority of these issues were raised as concerns in August 2021, and significant progress has been made including the appointment of a neonatal pharmacist, implementation of a new Prescribing SOP, auditing and development of document standards and changed practice regarding intubations with the provision of a new securing tape

2.11 Forward Plan

The findings of the Deep Dive report have been accepted and there is on-going work to expand the existing Neonatal improvement plan to incorporate the additional recommendations. There are however ongoing discussions with the IMSOP panel to provide clarity around some elements of the recommendations

A process for the Health Board and IMSOP to jointly sign off and verify recommendations has been drafted pending ratification in March.

Clinical and operational / service management Leads have been identified for each of the seven themes outlined to oversee the specific programmes of improvement work. Front line staff will be supported to lead drive and influence aspects of the improvements with the aim to ensure quality improvements become a part of normal practice.

It should be noted that whilst the Deep Dive review focused on the Neonatal Unit at PCH, the programme of improvements has included Neonatal Colleagues and teams at the POW Unit who are actively engaged with the process .

The development of the Neonatal vision will be a key part of the CTM2030 clinical strategy and the Starting Well programme of work. There is work to align the improvements and ensure that the Neonatal programme of work is better able to respond to our inequalities and capture clinical outcomes

3. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

3.1 A communications plan for the publication was agreed and delivered with onsite and virtual presentations, offers of direct support and supervision to staff with drop in sessions across the staff groups.

3.2 It should be noted that the IMSOP panel considers that current services are regarded as *viable* and improvements are able to be made

3.3 The panel recognised the progress of the improvement journey to date

3.4 The panel recognised the adverse impact of Covid on the service and the delivery against improvement plans.

3.5 The panel visited both Units, week commencing February 28th – informally the panel reported positive feedback but a formal report is pending.

4. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 The committee are asked to note this report, the progress made and the plans in place to address the recommendations of the Deep dive report.

4.2 Regular reporting of progress will continue through the existing Maternity and Neonatal Programme Highlight report, which the Committee receives regularly.

5. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	See above
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
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.
	Not required for this update report
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Investment will need to be continued into the Neonatal Improvement Team and service to ensure continued progress. Business Cases will be submitted as needed.
Link to Strategic Goals	Improving Care

6. RECOMMENDATION

6.1 The Quality and Safety Committee are asked to **NOTE** the report.