

AGENDA ITEM
6.2.2

QUALITY & SAFETY COMMITTEE

NHS DELIVERY UNIT FINDINGS REPORT: CTMUHB MATERNITY AND NEONATAL SERVICES SERIOUS INCIDENTS ASSURANCE REVIEW & BOARD SYSTEMS AND PROCESSES FOR REPORTING, MANAGEMENT AND REVIEW OF PATIENT SAFETY INCIDENTS

Date of meeting	(19/07/2022)
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FOI Status	Open/Public
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If closed please indicate reason	Not Applicable - Public Report
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Prepared by	Louise Mann, Assistant Director, Quality Safety & Safeguarding
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Presented by	Louise Mann, Assistant Director, Quality Safety & Safeguarding
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Approving Executive Sponsor	Executive Director of Nursing
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Report purpose	FOR DISCUSSION / REVIEW
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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	
	All explained within the report

1. SITUATION/BACKGROUND

The Committee has previously been updated in relation to progress made by the health board, supported by the NHS Delivery Unit (DU), in respect of the investigation and closure of 72 legacy maternity and neonatal serious incidents, in addition to the improvements required to the systems and processes in relation to incident management and learning.

The DU assurance review completed in May 2022, with Maternity, Neonatal and Corporate Quality and Safety (Q&S) teams having made significant strides towards the Royal College of Obstetrician & Gynaecology (RCOG) and Royal College of Midwives (RCM) recommendation, with incident management now in a much more robust place. This has been achieved through strengthening the quality of the investigation process and governance arrangements, including, assurance, escalation and leadership. As a result external agency recommendations have been met with the appropriate levels of assurance in place across the recommendations to confirm this position.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING

- **Maternity and Neonatal Serious Incidents Assurance Review**

Prior to the DU being commissioned to undertake an assurance review of maternity and neonatal serious incidents, a targeted intervention into the broader systems and processes for reporting, managing and review of patient safety incidents and relevant concerns had previously been commissioned. Following the escalation of concerns from this and the Royal Colleges' Review into maternity services, the Welsh Government (WG) took the decision to place the CTMUHB maternity services into special measures, and the overall health board into targeted intervention in March 2019.

The DU was satisfied that the 72 investigations have been completed to an appropriate standard with the quality of them comparable with other health boards; some of the new practices implemented make a good benchmark for other health boards to measure themselves against. Many of the improvements made to the incident investigation process have now been embedded as normal practice.

- **Management and Review of Patient Safety Incidents**

It is identified in the DU report that the CTMUHB have made significant improvements to the governance of quality and safety, including the management of incident and concerns, risks and patient safety. This was also reflected in the May 2021 joint Audit Wales and Healthcare Inspectorate Wales review of progress against recommendations following the original review into quality governance arrangements in CTMUHB (November 2019).

The DU report that the Health Board is well placed to build on the improvements that have been put in place both for maternity/neonatal services and more broadly across its quality governance arrangements, in line with the recommendations of both the RCOG/RCM and joint Audit Wales and Healthcare Inspectorate Wales recommendations.

Recommendations

- **In relation to Maternity and Neonatal Services Serious Incidents Assurance Review**

Whilst CTMUHB have some further improvements to make in relation to the recommendations of the RCOG/RCM recommendations and further recommendations of the NHS Wales DU assurance report, it should be recognised that significant improvements and progress has been made to the quality of managing serious incidents with the maternity and neonatal services. Any gaps in assurance in relation to the RCOG/RMN recommendations are clearly identified and RAG rated.

As a result of the significant progress made to date and clear understanding of the continuous improvement requirements and how they need to be managed moving forward within CTMUHB, the levels of assurance achieved against all recommendations the DU recommends that the 72 serious incident progress to closure and the formal assurance review be closed. An incident closure and executive sign off process has been agreed with WG and is almost complete.

It is also highlighted by the DU that the new Maternity and Neonatal services improved management of care quality and patient safety is not lost in the current organisational restructure; it is recommended the Maternity Quality Assurance Framework helps to inform the new CTMUHB structure to ensure this does happen.

Whilst significant improvements have been made to meet the recommendations of both reviews, the Maternity, Neonatal and Corporate Quality & Safety teams are on a continuous improvement journey. This is of particular note for the Neonatal team that are not as far down the journey of improvement having been included in the IMSOP clinical review.

- **In relation to Intervention into Board Systems and Processes for Reporting, Management and Review of Patient Safety Incidents**

Through the self-assessment and supporting evidence of progress against the recommendations of their original review into Quality Governance arrangements at CTMUHB, the DU now report appropriate levels of assurance. The DU report that significant improvements have been made to quality and safety governance, accepting, as also identified in the

AW/HIW progress review, CTMUHB are on an improvement journey with further improvements to be made. Any gaps in assurance in relation to the Targeted Intervention recommendations are clearly identified and RAG rated.

As a result of the comprehensive review, the DU recommended that the targeted intervention into the Board Systems and Processes for Reporting, Management and Review of Patient Safety Incidents be closed, and that the DU continue to monitor CTMUHB's progress as part of its standard quality and safety assurance monitoring process.

The DU also concluded that the Health Board demonstrated strong leadership, engagement and a determination to put things right. In particular, the Central Team involvement has had a significant impact on improving the quality of incident management supporting the Maternity and Neonatal services and supporting the governance of quality at service and ILG levels. This service to board approach was noted to be key to achieving the pace of change to date. There is positive multidisciplinary leadership and engagement team working and a shared accountability for of patient safety. Finally noting that the Health Board and its Maternity and Neonatal services are well placed to build on the actions and the improvements identified in this report and mature their approach to that of exemplar status.

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 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.
- ✓ 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

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	This report outlines key areas of improvement in maternity/neonatal services and quality across the Health Board.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	This report applies to all Health and Care Standards.
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 yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
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

Members of the Quality & Safety Committee are asked to:

- 5.1 **NOTE** the content of the report
- 5.2 **DISCUSS** the content of the report and flag areas (if not already identified) where further assurance is required
- 5.3 **NOTE** the risks and assurance identified
- 5.4 **SUPPORT** the assurance provided by the DU review.