GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
6.2

QUALITY & SAFETY COMMITTEE

MATERNITY AND NEONATAL PROGRAMME UPDATE

Date of meeting	20/09/2022

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FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

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Presented by	Suzanne Hardacre -Director of Midwifery & Nursing
Approving Executive Sponsor	Executive Director of Nursing

Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
MNIB Huddle – extraordinary meeting Greg Dix, Executive Nurse Director And Sallie Davies, Deputy Medical Director/Corporate Development	09/09/2022	ENDORSED FOR APPROVAL

ACRONYMS	
CFS	Conditions for Sustainability
IMSOP	Independent Maternity Services Oversight Panel

IPAAF	Integrated Performance Assessment & Assurance Framework
MNIB	Maternity & Neonatal Improvement Board
MNIP	Maternity & Neonatal Improvement Programme
MIP	Maternity Improvement Programme
NIP	Neonatal Improvement Programme
PCH	Prince Charles Hospital
PIDs	Project Initiation Documents
PMO	Project Management Office
QLM	Quality of Leadership & Management
QWE	Quality of Women's Experience
RCOG	Royal College of Obstetricians & Gynaecologists
RCM	Royal College of Midwives
RGH	Royal Glamorgan Hospital
SEC	Safe & Effective Care
SRO	Senior Responsible Officer

1. SITUATION/BACKGROUND

In April 2019, the Royal College of Obstetrics and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) published the findings of their joint Independent Review of Maternity Services at the former Cwm Taf University Health Board. The Welsh Government appointed the Panel to identify if the care provided at our Health Board was appropriate and, if not, what learning and improvements could be identified.

In 2020, the Health Board requested that an external review of its Neonatal Services at Prince Charles Hospital (PCH) be undertaken as part of the Panel's assurance processes for Maternity Services. This review was requested following routine reviews of care on the Neonatal Unit at PCH, and the former unit at the Royal Glamorgan Hospital (RGH), which senior clinicians felt, in some cases, could be improved. A review of Neonatal Services termed a 'Deep Dive' started in May 2021.

In August 2021, the Panel escalated concerns to Welsh Government

regarding some elements of care at the Neonatal Unit at PCH with some areas needing urgent action. Immediate action was taken to begin to address these concerns.

In February 2022, the Neonatal Deep Dive review was published. This consisted of 42 recommendations of which 5 are immediate plus a further 14 escalations, grouped into the following seven key themes:

1. Family engagement and support
2. Governance, Assurance and Accountability
3. Neonatal Service Workforce
4. Reporting
5. Neonatal Unit Functionality
6. Neonatal Unit Safety
7. Clinical Case Assessments

The key **overarching areas** of improvement for both Maternity and Neonatal were as follows:

- Quality of Leadership Management **(QLM)**
- Safe and Effective Care **(SEC)**
- Quality of Women and Families Experiences **(QWE)**

This report summarises the work of the MNIP:

- **Maternity and Neonatal Improvement programme** – structure and governance
- **Assurance processes**
- **Maternity RCOG recommendation -** completion
- **Closure of MIP**
- **Neonatal Improvement programme -** progress

1.1 The approach to deliver the Maternity and Neonatal Improvement Programme (MNIP) was developed to ensure the following were in place:

  - **Programme management;**
  - **Leads for each of the work-streams;**
  - **Project Initiation Documents (PIDs);**
  - **MNIP Board (MNIB);** governance structure; improvement team; Project Management Officer (PMO); project plans; risks and mitigating actions; programme report; performance metrics;
  - **Independent Maternity Services Oversight Panel (IMSOP) engagement**; IMSOP showcases; IMSOP on-site visits; submission of evidence;
  - **Integrated performance & Assurance framework (IPAAF);**
  - **Conditions for sustainability**; including Senior Responsible Officer (SRO) challenge sessions.

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

Through the approach above along with assurance processes (predominantly the submission of evidence to IMSOP); showcases; documentation; IPAAF and Conditions for sustainability, challenge sessions with SRO's/Independent Health Board Member, the following assessments were made:

Integrated Performance Assessment & Assurance Framework (IPAFF) - Maternity & Neonatal

All assessments undertaken in accordance with IPAAF Maturity Matrix 'Specific Wording'.

- Maternity Self-Assessment (25.7.22)
- Neonatal Self-Assessment (26.7.22)
- SRO Challenge Session (3.8.22)
- IMSOP Feedback (8.8.22 at IMSOP Huddle)
- Neonatal 'revised' Self-Assessment (15.8.22)
- IMSOP Neonatal feedback received – agreed with CTMUHB Self-Assessment

IPAAF session summary:

Integrated Performance Assessment & Assurance Framework August 2022			
Quality of Leadership & Management (QLM)		Maternity	Neonates
	Service Assessment	Early Maturity	Results
	SRO Challenge	Early Maturity	Results
	IMSOP	Early Maturity	Results
Safe & Effective Care (SEC)	Service Assessment	Maturity	Results
	SRO Challenge	Maturity	Results
	IMSOP	Maturity	Results
Quality of Women & Families Experience (QWE)	Service Assessment	Exemplar	Results
	SRO Challenge	Exemplar	Results
	IMSOP	Exemplar	Results

Following IPAAF Challenge, work has progressed to close the following Maternity work-streams:-

- Safe & Effective Care
- Quality of Leadership & Management
- Quality of Women's Experience.
- Maternity & Neonatal Collaborative Work-stream

Preparations are underway for the Programme to transition all outstanding actions onto a Milestone plan for which oversight will be provided according to the updated Maternity and Neonatal Assurance Framework (Appendix A).

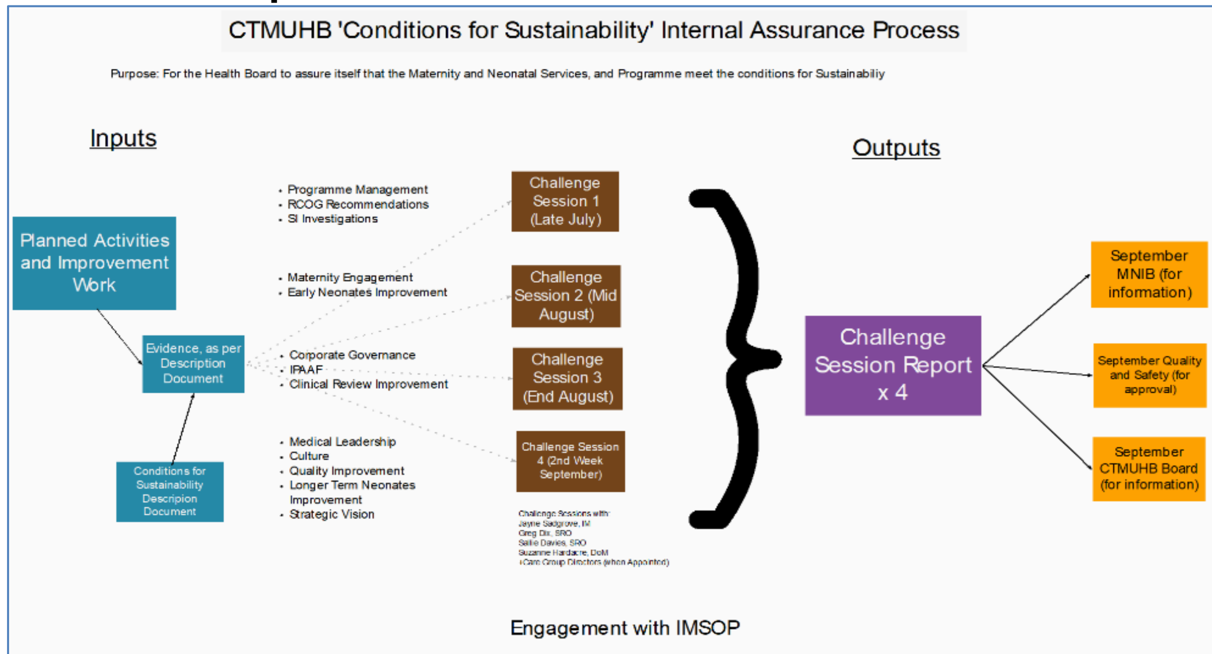
Conditions for Sustainability (CfS):

The following were the identified CfS criteria:

Corporate Governance	Effective oversight and scrutiny of current maternity and neonatal service provision consistently being provided by the Board and the Quality and Safety Committee (Q&SC).
Serious Incident Investigation	NHS (Wales) Delivery Unit recommendations delivered and signed off; effective investigations being conducted on a 'business as usual' basis; all learning is routinely being identified and shared and there is evidence that this is driving improvements in care.
Royal Colleges' Recommendations	The Royal Colleges' recommendations process is discharged; all recommendations are either verified as delivered by the Panel or scheduled for delivery within the Health Board's longer-term Maternity and Neonatal Improvement Plan.
Early Neonatal Improvement	Recommendations within the Neonatal Deep Dive Report which require immediate action are verified as completed by the Panel and impacting positively on unit safety; a plan to deliver the remaining recommendations has been developed and agreed by the Panel.
Clinical Review Programme	Clinical Review Programme is fully completed; emerging recommendations and Health Board actions have been fully addressed.
Maternity Engagement Strategy	Strategy being delivered to plan and timescale; PREMs process embedded; evidence that outputs of PREMs and data from other engagement sources is being systematically evaluated and driving tangible service improvement.
Medical Leadership	Medical leadership is visible and effective; there is leadership development support in place and the consultant body as a whole is actively engaged in driving forward service improvement.
IPAAF	IPAAF is being used effectively at service and Board level to regularly reflect upon and evaluate progress; maternity service assessed at 'maturity' level for safe and effective care with other domains progressing towards maturity; neonatal service assessed at 'results' level in all three domains; early evidence of progress against agreed key metrics.
Quality Improvement (QI)	A QI approach is in place, aligned to the corporate iCTM arrangement; QI plan and active QI projects are in place with evidence that small scale incremental changes are being delivered.
Programme Management	Effective programme management structure is in place, which defines the objectives of the improvement work, has plans which show how the work is delivered and what barriers could impact on delivery or outcomes; structure has effective, open and transparent reporting, with effective Board oversight.
Culture Change	There is evidence of positive shifts in culture in key areas such as joint working between maternity and neonatal services, multidisciplinary working and addressing the blame culture.

Longer-term Neonatal Improvement	Longer-term improvement plans are credible with a clear timeline and trajectory; there is evidence of meaningful progress against those elements of the improvement plan requiring short- and medium-term responses, in particular those recommendations linked to engagement with families.
Strategic Vision	Developed, agreed and communicated to the public; early actions delivered providing confidence that sustainable longer-term continuous improvement is achievable.

CfS assurance process:



Note: Above challenge sessions were adjusted to include/exclude relevant items based on previous evidence submissions and showcases.

The following SRO/independent HB member **challenge sessions were held:**

Challenge session	Date held	Outcome
Challenge Session 1 ○ Royal Colleges' Recommendations ○ IPAAF ○ Programme Management	4th August 2022	Approved
Challenge Session 2 ○ Serious Incidents ○ Engagement	16th August 2022	Approved
Challenge Session 3 ○ Clinical Review ○ Corporate Governance	22nd August 2022	Approved
Challenge Session 3 ○ Neonatal Immediate Recommendations (also see below) ○ Longer Term Neonate Recommendations	To be held 21st Sept 2022	tbc

Additional		
QI	Showcase at IMSOP site visit 7th Sept 2022	Preliminary feedback **very good** – *official IMSOP report awaited*
Long term Strategy	Showcase at IMSOP site visit 7th Sept 2022	Preliminary feedback **very good** – *official IMSOP report awaited*
Neonatal Immediate Recommendations (19)	Plan shared with IMSOP 26th Aug 2022	Feedback – **good. To date 10 signed-off by IMSOP**; plan for delivery of remaining 9 on-track

Maternity Improvement Programme – completion and closure evidence submitted to IMSOP:

Paper	Purpose	Date of submission to IMSOP
Stillbirth Thematic Review 2021	CfS	12/9/22
Thematic analysis of concerns June to Aug 22	Requested at IMSOP onsite visit 7/9/22	12/9/22
LNA documents (various)	CfS	12/9/22
Leadership and Culture detailed plan	CfS	12/9/22
Maternity and Neonatal Strategy 2022 v3 CTM 2030 – Strategy and MNIP overview draft v2 6.9.22	CfS	12/9/22
Programme Transition arrangements (various): ○ MNIP Transition arrangements Aug 22 FINAL ○ Maternity and Neonatal Assurance framework draft v4 EXECS – Mar 22 ○ Maternity and Neonatal Assurance Framework Draft v4 Care group Model 19.8.22 ○ Quality Governance Framework Nov 2020 FINAL v2 ○ Operating Model Governance Patient safety in care groups OCP Aug 22 ○ CTMHB Listening and Learning framework ○ Delivery Unit CTMHB final report	CfS	12/9/22

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

- MNIP improvement roles – sustainability beyond March 2023.
- A maternity and neonatal workforce plan for 2023 and beyond is in development to ensure that improvement work is sustainable.
- Improvements are being embedded into business as usual practices
- Director of Midwifery & Programme Manager meeting regularly with IMSOP & Welsh Government to ensure all Conditions of Sustainability are being progressed and/or achieved.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below) The progress of the MNIP has demonstrated assurance against all domains and conditions for sustainability.
Related Health and Care standard(s)	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below: • **Safe care** • **Effective Care** • **Staff and Resources**
Equality Impact Assessment (EIA) completed - Please note EIAs are required for all 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	Yes (Include further detail below) There is a possibility that workforce plans will highlight a need for additional resource to achieve continuous improvement and embed all learning, conditions for sustainability as 'business as usual'.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Quality and Safety Committee are asked to **NOTE** the report; the closure of the Maternity Improvement Programme and new governance arrangements going forward.