AGENDA ITEM
6.1.3

QUALITY & SAFETY COMMITTEE

ROYAL COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS AND THE ROYAL COLLEGE OF MIDWIVES REPORT RECOMMENDATIONS CLOSURE REPORT

Date of meeting	24th May 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Steve Sewell, Programme Director Maternity & Neonatal Improvement Kathryn South, Maternity Experience & Engagement Lead
Presented by	Greg Dix, Executive Nurse Director Sallie Davies, Deputy Medical Director
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	ENDORSE FOR BOARD APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Maternity and Neonatal Improvement Board	31st March 2022	SUPPORTED

ACRONYMS
QI - Quality Improvement IMSOP – Independent Maternity Services Overview Panel RGH – Royal Glamorgan Hospital PCH – Prince Charles Hospital

SITUATION / BACKGROUND

1.1 The Royal Colleges report of April 2019, reviewing Maternity Services at Cwm Taf University Health Board identified 70 recommendations. This report was focused on services at RGH and PCH as the report was published prior to the closure of the Obstetrics and Neonatal unit at RGH and before the boundary change which saw the creation of Cwm Taf Morgannwg University Health Board.

1.2 Since the establishment of the IMSOP panel, their terms of reference have included the oversight of the delivery and reviewing of evidence against these 70 recommendations.

1.3 In the most recent IMSOP update report to the Health Minister (October 2021), IMSOP signalled that continuing to use the original recommendations as a measure of improvement progress was no longer effective for an increasingly complex programme, which now extends beyond the scope of the 70 recommendations. The programme management structure was highlighted as being a better gauge of progress, utilising workpackages, milestone plans and highlight reporting against milestones and key metrics.

1.4 This paper signals the shift from a focus on Royal Colleges recommendations to the programme management structures in the improvement programme.

1.5 In February 2022, 55 of the 70 Royal College recommendations had been verified by IMSOP, with 10 of these labelled as needing follow up.

1.6 This paper sets out the current position, proposes the closure of all Royal Colleges' recommendations, and describes the remaining elements of these recommendations that need to be reflected within the Maternity and Neonatal Improvement Programme Plans.

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

2.1 Recently the improvement programme has drawn together evidence against each of the remaining recommendations for review by IMSOP. Additionally, IMSOP recently visited the Maternity and Neonatal services from 28th February to 2nd March 2022 with many assurance activities scheduled to demonstrate progress against the Royal Colleges' recommendations. We've received feedback from IMSOP which provides their view of the material they reviewed against the remaining recommendations.

2.2 In February 2022, there were 15 open recommendations, and following IMSOP review of the recently submitted evidence, seven of these recommendations have been fully verified by IMSOP. The remainder have undelivered elements that will

need to be included within the improvement programme plan. We have provided a summary for each of the 15 open recommendations within Appendix 1.

2.3 The Maternity and Neonatal Improvement Programme felt that three of the open recommendations were suitable for internal assurance of available evidence prior to presenting to IMSOP. The outcome of the internal review was:

	Recommendation	Recommendation to MNIB
7.17	Ensure Training is provided for all SAS staff	**Approve**
7.35	Undertake a training needs assessment for all staff to identify skills gaps and target additional training	**Partial Approval**: the improvement programme plans need to have milestones to achieve training compliance and complete the LNA work. The Training compliance has almost been achieved, but this compliance should be reported through programme highlight reporting for at least 3 months. Alongside the milestones for the delivery of a Learning Needs Analysis, there should be a description of the final output, which can be used to ensure the end output has reached the expected outcome
7.45	Provide mentorship and support to the Clinical Director	**Approve**. Assuming recent conversations between Mohamed Elnasharty (MCILG Obs and Gynae Clinical Director) and Alan Cameron (IMSOP panel) provided assurance.

2.4 There were 10 follow up recommendations and a summary of the latest position for each is shown in Appendix 2. IMSOP have stated that eight of these no longer require any further follow up.

2.5 The Health Board assessment of the remaining elements of the recommendations that need to be included within the Improvement Programme plan are as follows:

- Statutory Training Compliance
- Learning Needs Analysis
- Leadership Development Plan and Activities
- Culture Development Plan and Activities
- Maternity and Neonatal Strategy
- Embedding of Complaints and Concerns processes
- GAU (Gynaecology Assessment Unit) building works and service 'Go Live' date.

2.6 Most of these elements already sit within the Improvement Programme Plan and for those not yet fully included, the programme will need to demonstrate to the Board and IMSOP that they have been within the next few weeks.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

None

4 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below Dignified Care Effective Care Individual Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	Choose an item. 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.
	This relates to existing services.
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

5.1 The Quality and Safety Committee is asked to **recommend Board approve the closure of the Royal College recommendations**, noting the elements that will need

to be included within Improvement Plans. The governance of these plans will be monitored by MNIB reporting up to Q&S and transition to the proposed new Women & Children (W&C) care group as part of the revised new operating model.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Appendix 1 - Summary of Open Recommendations

	Recommendation Description	Proposed Status
7.1	Urgently review systems in place for: • data collection, • clinical validation, • checking the accuracy of data used to monitor clinical practice and outcomes, • and what information is supplied to national audits.	**Close**: Submitted evidence meets remaining requirements.
7.7	Ensure an environment of privacy and dignity for women undergoing abortion or miscarriage in line with agreed national standards of care.	**Close with all elements outstanding**: Evidence provided did not recommendation requirements. Plans for the Gynaecology Assessment Unit need to be reviewed in detail and key dates for completion need to be added to the improvement plan.
7.8	Ensure external expert facilitation to allow a full review of working practice to ensure: • patient safety is considered at all stages of service delivery, • a full review of roles and responsibilities within the obstetric team, • the development and implementation of guidelines, • an appropriately trained and supported system for clinical leadership, • a long term plan and strategy for the service, • there is a programme of cultural development to allow true multi-disciplinary working.	**Administrative Closure**: Evidence previously provided meets the requirement for some elements of this recommendation. However, the remaining aspects overlap with the strategy development work (**7.67**) and duplicated.
7.17	Ensure training is provided for all SAS staff to ensure that they are: • up to date with clinical competencies, • skilled in covering high risk antenatal clinics and out-patient sessions.	**Close**: Evidence provided meets recommendation requirements
7.19	Ensure that a system for the identification, grading and investigation of SIs is embedded in practice, through: • appropriate training to key staff members, • making investigations multidisciplinary and including external assessors.	**Close**: Evidence provided meets recommendation requirements
7.20	Actively seek to remove the 'blame culture' to allow all staff to develop a willingness to report and learn from SIs.	**Close**: Evidence provided meets recommendation requirements
7.31	Ensure a robust plan of births anticipated in each midwifery led unit and consultant led unit is undertaken, • ensure involvement of paediatric staff for all future service design reviews and actions.	**Close with some outstanding elements**: Strategy development needs to include long term demographic planning and demand modelling for future births. This should be jointly completed by the maternity and neonatal services based on agreed strategic service change principles.
7.35	Undertake a training needs assessment for all staff to identify skills gaps and target additional training.	**Close with some outstanding elements**: Improvement programme plans need to demonstrate achievement of statutory training compliance and the completion of a Learning Needs Analysis which builds on the Training Needs Analysis already in place for maternity services

	Recommendation Description	Proposed Status
7.44	Support training in clinical leadership, • the Health Board must allow adequate time and support for clinical leadership to function.	**Closed with some outstanding elements:** Improvement programme plans need to include agreed Leadership Development Plan activities.
7.45	Provide mentorship and support to the Clinical Director • define the responsibilities of this role, • ensure there are measurable performance indicators, • ensure informed HR advice to consistently manage colleagues' absence and deployment of staff to cover the needs of the service, • consider buddying with a Clinical Director from a neighbouring Health Board.	**Close**: Evidence provided meets recommendation requirements.
7.51	Ensure responses to complaints and concerns is core to the work being undertaken to improve governance and patient safety: • Review and enhance staff training on the value of listening to women and families, • Review the process of investigation of concerns, compiling responses, handling 'on the spot' issues and ensure that all responses and discussions are informed by comprehensive investigations and accurate notes, • Prioritise the key issues that women and families have highlighted to improve the response, • Ensure that promises of sharing notes and providing reports to families are delivered, • Clarify the process regarding the triangulation of the range of information sources on patient experience, SIs, complaints and concerns and other data and ensure that there is a rigorous approach to make sense of patterns of safety and quality issues, • Review the learning from the SIs in relation to misdiagnosis, failure to seek a second opinion and inappropriate patient discharge.	**Close with all elements outstanding:** Improvement programme plans need to include embedding of complaints, concerns and clinical incidents into service governance, with regular reporting, service improvements resulting from the data, and periodic thematic reports.
7.56	Provide training for staff in communications skills, in particular on: • Empathy, compassion and kindness.	**Close with all elements outstanding:** Improvement programme plans need to include Culture Development plan activities.
7.63	Independent Board members must challenge the quality of the data which informs the reports which they receive and rely upon for assurance.	**Close with some outstanding elements**: Development of a Maternity Service Dashboard and a data driven reporting culture is required to enable Members to make independent judgements. This needs to be encompassed in the longer term improvement programme plans.
7.67	Develop a strategic vision for the maternity service and use the current opportunity of change to create a modern service which is responsive to the women and their families and the staff who provide care.	**Close with all elements outstanding:** Improvement programme plans need to include plans to develop a strategy for Maternity and Neonatal services within the context of the wider CTM2030 strategy.
7.70	Ensure that any future service change for the development process of the maternity service as a whole is inclusive for all staff and service users.	**Administrative Close**: Due to a significant overlap, this recommendation has been merged with 7.67.

	Recommendation Description	Proposed Status
	•Ensure the service is adequately staffed to ensure that all staff groups are able to participate in developing the vision •Consider an externally facilitated and supported process for review. •Consider seeking continued support from HIW and the Royal Colleges to undertake a diagnostic review of the service particularly in relation to changes in service provisions.	

Appendix 2 – Summary Follow On recommendations

	Recommendation Description	Proposed Status
7.05	Agree a CTG training programme that includes a competency assessment which is delivered to all staff involved in the care of pregnant women, both in the antenatal period and intrapartum.	**Close:** Evidence provided meets recommendation requirements. Training compliance will be demonstrated in the outstanding element of **7.35**.
7.18	Agree cohesive methods of consultant working after the merger with input from anaesthetic and paediatric colleagues.	**Close**: Evidence provided meets recommendation requirements.
7.22	Actively discuss the outcomes of SIs in which individual consultants were involved in their appraisal.	**Close**: Evidence provided meets recommendation requirements.
7.23	Improve learning from incidents by sharing the outcomes from SIs on a regular basis and in an appropriate, regular and accessible format.	**Close**: Evidence provided meets recommendation requirements.
7.27	Consider extra resource to the Maternity Governance and Risk team to ensure: • workload is manageable, • that Datix are reviewed, graded and actioned in an appropriate and timely manner.	**Close with some outstanding elements:** Improvement programme plans need to include a review of resourcing in six months' time.
7.30	Ensure the Medical Director has effective oversight and management of the consultant body by: • making sure they are available and responsive to the needs of the service, • urgently reviewing and agreeing job plans to ensure the service needs are met, • clarifying what is to be covered as part of SPA activity (audit, governance, teaching, guidelines, data assurance, train more consultant obstetricians as appraisers), • ensuring the most unwell women are seen initially by a consultant and all women are seen by a consultant within 12 hour NCEPOD recommendation4 (national standard).	**Close with some outstanding elements:** Improvement programme plans need to include an audit in six months' time to ensure national standard is being consistently met.
7.32	Ensure obstetric consultant cover is achieved in all clinical areas when required by: • reviewing the clinical timetables to ensure that 12 hour cover per day on labour ward is achieved,	**Close**: Evidence provided meets recommendation requirements.

	Recommendation Description	Proposed Status
	• undertake a series of visits to units where extended consultant labour ward presence has been implemented. • considering working in teams to ensure a senior member of the team is available in clinics and provide cross cover for each other, • considering the creative use of consultant time in regular hours and out of hours to limit the use of locums.	
7.36	Clinical supervision and consultant oversight of practical procedures must be in place for all staff including specialist midwives and staff doctors.	**Close**: Evidence provided meets recommendation requirements.
7.37	Develop an effective department wide multi-disciplinary teaching programme. • this must be adequately resourced and time allocated for attendance by all staff groups including specialist clinical midwives and SAS doctors. • attendance must be monitored and reviewed at appraisal.	**Close**: Evidence provided meets recommendation requirements.
7.40	Review the skills and competencies of the senior clinical midwives covering for tier 1 doctors to ensure: • their scope of practice is clearly defined, • the Health Board and the individuals are protected against litigation risk for their extended roles.	**Administrative Close**: These identified roles no longer exist.