AGENDA ITEM
6.1

QUALITY & SAFETY COMMITTEE

MATERNITY AND NEONATAL IMPROVEMENT PROGRAMME UPDATE

Date of meeting	24/01/2023

C=

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Shelina Jetha - MNIP Programme Manager
Presented by	Greg Dix - Executive Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing

Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
MNIB Huddle – Greg Dix, Executive Nurse Director And Sallie Davies, Deputy Medical Director/Corporate Development	14/12/2022	SUPPORTED

ACRONYMS	
IMSOP	Independent Maternity Services Oversight Panel
MNIB	Maternity & Neonatal Improvement Board
MNIP	Maternity & Neonatal Improvement Programme
MIP	Maternity Improvement Programme

NNIP	Neonatal Improvement Programme
ESC.	Escalation (as per Neonatal Deep dive recommendations)
PCH	Prince Charles Hospital
BSOTS	Birmingham Symptom specific Obstetrics Triage system
PERIprem	Perinatal Excellence to Reduce Injury in Premature Birth
PMO	Project Management Office
datix	System for reporting incidents
AMAT	Audit management tracking
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
SBAR	Situation, background, assessment and recommendation
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 an Independent Maternity Services Oversight Panel (IMSOP) that consisted of Obstetrics and Neonatal specialists 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 were 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

Note: The position of the progress on the Neonatal recommendations are detailed further in this paper.

In light of the NN deep dive recommendations, a Maternity and Neonatal improvement Programme (MNIP) was set-up to deliver the improvements. This included a robust programme structure with programme plans with deliverables; governance and accountability; highlight reports for both external and internal stakeholders; risks register with mitigating actions etc. Also plans for transition of the improvements into business-as-usual practices in service after the end of the programme. Furthermore, the health board worked with IMSOP to identify 'conditions for sustainability' to ensure progress on the delivery and sustainability of the improvements.

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

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

On 7th Nov 2022, Welsh Government announced Maternity services were removed from special measures *(for full details see link below)* and both Maternity and Neonatal services would be placed into targeted interventions. Key summary as follows:

- **Decision to de-escalate -** *the HBs maternity and neonatal services from special measures to targeted intervention. This transition recognises the clear progress made over the last three-and-a-half years'*

- **Continuous/sustainable improvements** met
- **Maternity and Neonatal improvement journey** can now be considered sustainable
- **IMSOP on-site visit 5/7th Sept 2022** - assurance on maternity service markedly different compared to 2019
- **Families** continue to ensure their experiences help shape service design and delivery
- **Culture change** - HB leadership committed to working collaboratively with staff on positive cultural changes
- **Neonatal service still has some way to go in its improvement journey -** The merger of maternity and neonates in one care group structure will help to deliver sustainable improvements in neonatal care. Also, learning from previous experience in maternity services will be an asset for the development of safe sustainable improvements in neonatal care.
- **IMSOP standing down the oversight panel at the end of the year 2022**
- **Oversight and support -** Welsh Government to advise
- **National programmes** of work underway on maternity and neonatal service provision across Wales. Identify any improvements collaboratively with all HBs.
- **Learning from Clinical reviews** - CTMs improvement journey to feed into these programmes.

Welsh Government notification on MNIP and standing down on special measures to targeted interventions 7/11/22 see link below for full details of published report:
written-statement IMSOP progress-report published 7th Nov 2022
BBC news Wales report 7th Nov 2022

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

This paper summarises the on-going improvement work led by the maternity and neonatal improvement board.

1. **Gynaecological pathway –** clinical guidelines
2. **Neonatal Improvement programme -** progress
3. **NNAP -** update
4. **Maternity Improvement Plan (MIP) 'wash up plan' -** progress
5. **Putting things Right (PTR) –** complaints; NRI's etc.
6. **Training compliance -** update
7. **National mat/neo safety programme -** update
8. **Workforce**
9. **Risks/mitigations**

Gynaecological pathway

Gynaecological emergencies can arise at any time of the day. The introduction of early pregnancy units (EPU) has led to an organised assessment of women with complications of early pregnancy, the most common cause of emergency assessment. Thus, most of these women are seen within working hours. However, some women have severe symptoms, which cannot wait until an EPU opens, and others have non pregnancy related conditions. The emergency gynaecology and early pregnancy service should be consultant led, with decision-making made in a timely manner, and at a sufficiently senior level. The service should be women centred, safe, effective, evidence based and multidisciplinary.

Emergency gynaecology is available at PCH 24/7 on ward 5 and from December 2022 an AESU (A&E surgical unit) available for 12hrs/day in POW.

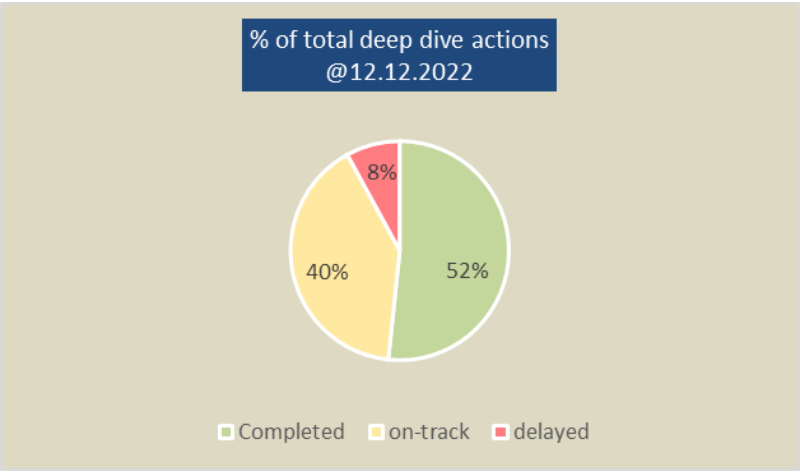
The following link is to the standards of service provision developed for the gynaecological pathway clinical guidelines and approved in April 2022:
Clinical guidelines emergency gynaecology and early pregnancy service April 2022

Neonatal Improvement programme (NNIP)

All of the 19 immediate actions from the deep dive recommendations had all been submitted to IMSOP by 30th September 2022 of which the following had not been verified:

- ***Esc 2*** *– IUT (intra uterine) pathway/close working between Maternity and Neonatal – pathway developed and to be implemented*
- ***Esc 5*** *– HIE (Hypoxic-ischaemic encephalopathy) cooling pathway and case example on improvements – awaiting a case.*
- ***Esc 7*** *– SI's (Serious incidents) renamed to NRI's/LRIs (National and local reportable incidents) – Trigger list audit completed; PMRT and NRI reports to be completed*

The following chart provides an overall summary on the progress on all deep dive actions as at 12.12.2022:



*Note: Delays are predominantly due to the outstanding immediate actions (as above, 2 **remaining** now on-track to be completed Jan 2023 and one pending on a HIE/cooling case) and 40% of remaining actions on-track i.e., short/medium with long-term delivery beyond Programme end 31/3/23.*

IMSOP stood down at the end of December 2022 hence, the following has been set-up to ensure all remaining deep dive actions are delivered, assured and improvements are embedded:

- **Please refer to Appendix 1 (attachment)** *'MATERNITY & NEONATES ASSURANCE, RISK & ESCALATION FRAMEWORK FINAL DECEMBER 2022 V5.0'*
- **Newly set-up 'Neonatal Operational Clinical Improvement Group' – first meeting to be held 9/1/2023 –** *multi disciplinary inclusive of Maternity where required to oversee implementation of improvements in BAU practices*
- **Revised NNIP plan** *(shared with Welsh Government 21.12.23)*
- **Using data for making service improvements –** *e.g. respiratory pathway, IUT pathway as QI projects; antibiotic stewardship; Normothermia – monitor temperature; golden drops – breastfeeding in collaboration Mat/Neo and reduce term admissions*
- **Programme led approach to delivery under review** *PMO ending 31/3/2023 (to be led by Clinical Improvement Lead)*

Maternity 'wash up plan'

This plan included outstanding items from the MIP and also those items that require collaborative working between Maternity and Neonatal services, as follows:

- **RCOG recommendation 7.3** – all women presented in A&E to be seen within 12hrs by a consultant. This target is the ambition for HBs across Wales and UK. It is not achievable within the current workforce model. However, a strategic workforce plan is being developed, inclusive of both Maternity and Neonatal in the new CTM governance structure. CTM HB is currently compliant with the 18 hours window. To date no safety incidents have been raised. **Action:** HB keep this under continuous review.
- **Transitional Care** – Data to be extracted from BadgerNet and pilot being scoped for POW as a trial.
- **Long term strategy** – formal launch to be arranged.
- **Culture survey** – to re-run and analyse results.
- **QI:**
    - **Maternity Data dashboard -** now live; staff provided with training; one process map across CTM; digital booking system to be tested Jan 2023/scale Feb 2023
    - **ATAIN** –QI training with Mat Neo Cohort 1 completed; Improvement in Practice training in October; Cohort 2 started November 22; MDT represented at training; engaging

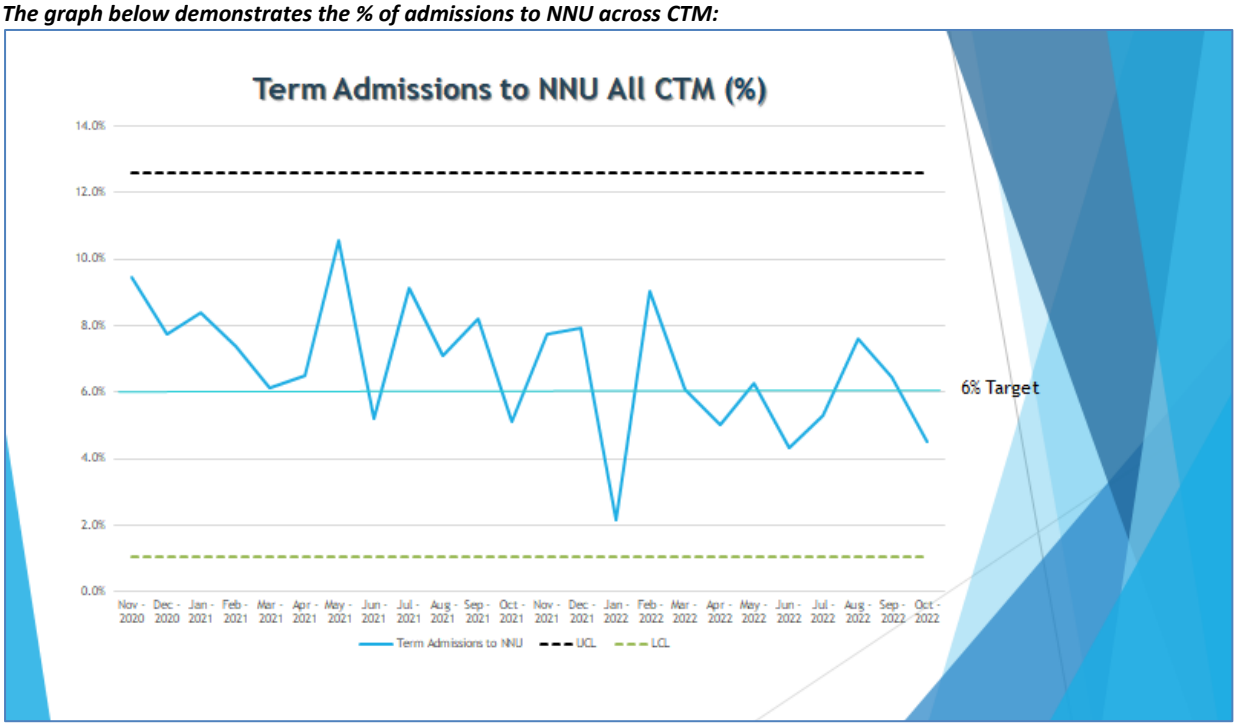
Obstetricians in QI training, with 1 booked in Cohort 3 to date in Nov 22; ATAIN dashboard developed; Mat/Neo team working collaboratively

- **BSOTS –** baseline data collected; good understanding of attendance; MDT at both sites; further engagement with staff and families; local adaptations; launch Feb 2023
- **PERIprem –** 11 QI projects identified and delivered in collaboration between maternity and Neonatal

*Note: **PERIprem** (Perinatal Excellence to Reduce Injury in Premature Birth) – this is a new care bundle developed in NHS England to improve outcomes for premature babies which CTM will be using for making improvements.*

Term admissions metrics

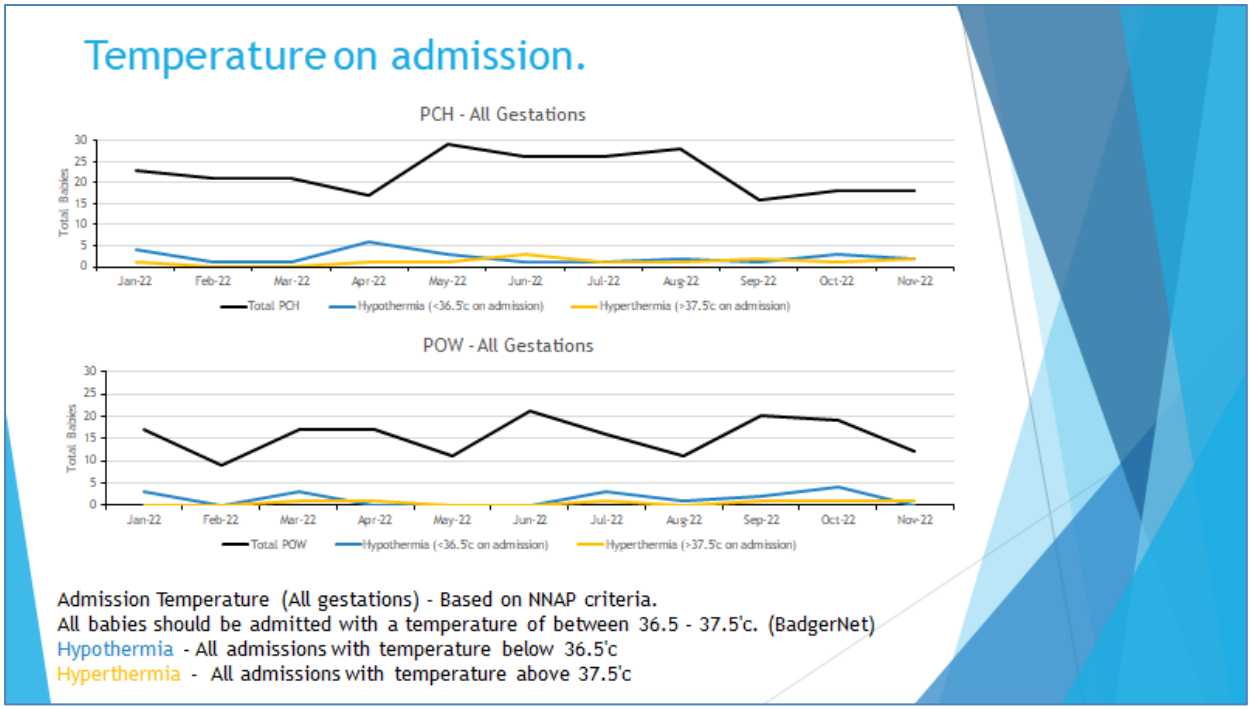
The graph below demonstrates the % of admissions to NNU across CTM:



*note: 6% target is a nationally set target. CTM - approx. 72% of term admissions are due to respiratory concerns. **Action:** Consultant led - respiratory pathway under review as part of QI project to be completed by 30th June 2023)*

Temperature on admission

The graph below demonstrates the infants temperature for PCH and POW:



*Note: **Action:** Consultant led - Normothermia QI project to improve processes for taking temperatures under review to be completed by 31st March 2023*

National Neonatal Audit Programme (NNAP) 2021 results

NNAP results for 2021 received; presentation to Mat/Neo clinicians 5th Dec and MNIB 14th Dec held. Mat/Neo collaboration to devise formal action plan from findings. **Actions for CTM**:

- **Data validation**
- **Peri prem QI project**
- **Thermoregulation QI project**
- **Staffing data analysis**
- **Maternity and Neonatal to develop formal approach to NNAP data/actions**

NNAP results can be found on this website: [NNAP Online (rcpch.ac.uk)]

Putting things Right (PTR)

Compliance against 30 working day target for Nov 2022

The following table presents the no. of complaints; resolved within the 30 day working day target; no. closed; total no. open and those that are >30days

Note: top 3 types of complaints relate to clinical treatment, appointments, and attitude & behavior.

No. of complaints 'closed'	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Number of complaints closed	10	8	19	11	8	5	9	8	1	5	2	6
Of the complaints closed, number responded to within 30 Working days	8	4	7	5	2	4	7	5	1	3	1	1
Complaints compliance response rate	80%	50%	37%	45%	25%	80%	78%	63%	100%	60%	50%	17%

Complaints 'open'	no. of complaints
Total no. of complaints open as at 8.12.22	30
Open complaints >30 days	17

All concerns are Quality Assured by the CD and HOM together: the process is lengthy and needs to be reviewed as women are waiting too long to have their concerns responded too. Please also note that some complaints also require an RCA investigation and therefore will breach the 30 day target. Note: The Health Board have recently transitioned from an Integrated Locality Model into a Care Group operating model and are also realigning the quality governance structure to support the new operating model. Therefore, reporting going forward will be aligned to the new Care Group model.

Maternity only clinical incidents by level of harm Nov 2022

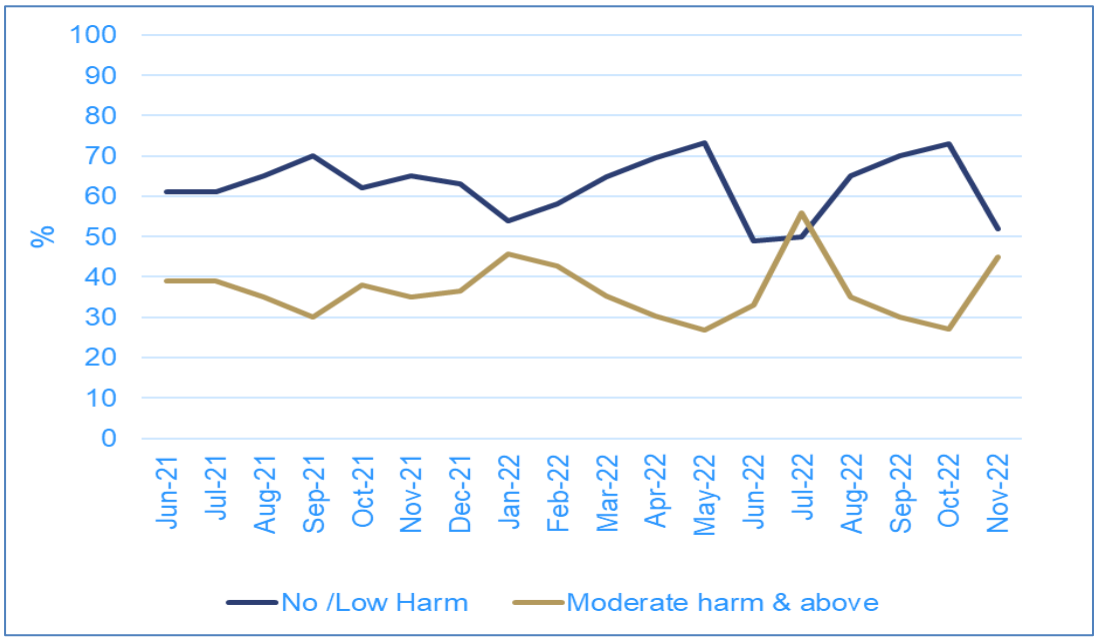
The following table presents the number of incidents by level of harm across CTM sites as at Nov 2022:

CTM site	None	Low	Moderate	Severe	Total
Community Sites	0	1	0	0	1
Other Sites	2	1	0	0	3
Prince Charles Hospital	22	22	25	1	70
Princess of Wales Hospital	24	23	19	0	66
Royal Glamorgan Hospital	4	3	0	0	7
Ysbyty Cwm Rhondda	0	2	0	0	2
Ysbyty Cwm Cynon	2	0	0	0	2
Total	**54**	**52**	**44**	**1**	**151**

The following table presents the type of incidents across CTM:

Type of incident	Total
Access, Admission	15
Accident, Injury	2
Assessment, Investigation, Diagnosis	10
Communication	12
Equipment, Devices	7
Information Technology	1
Infrastructure (including staffing, facilities, environment)	17
Maternity adverse occurrence	68
Medication, IV Fluids	4
Records, Information	2
Safeguarding	1
Transfer, Discharge	7
Treatment, Procedure	5
Total	**151**

The chart below shows the trend on % of clinical incidents by level of harm over a period between Jun 21 to Nov 22:

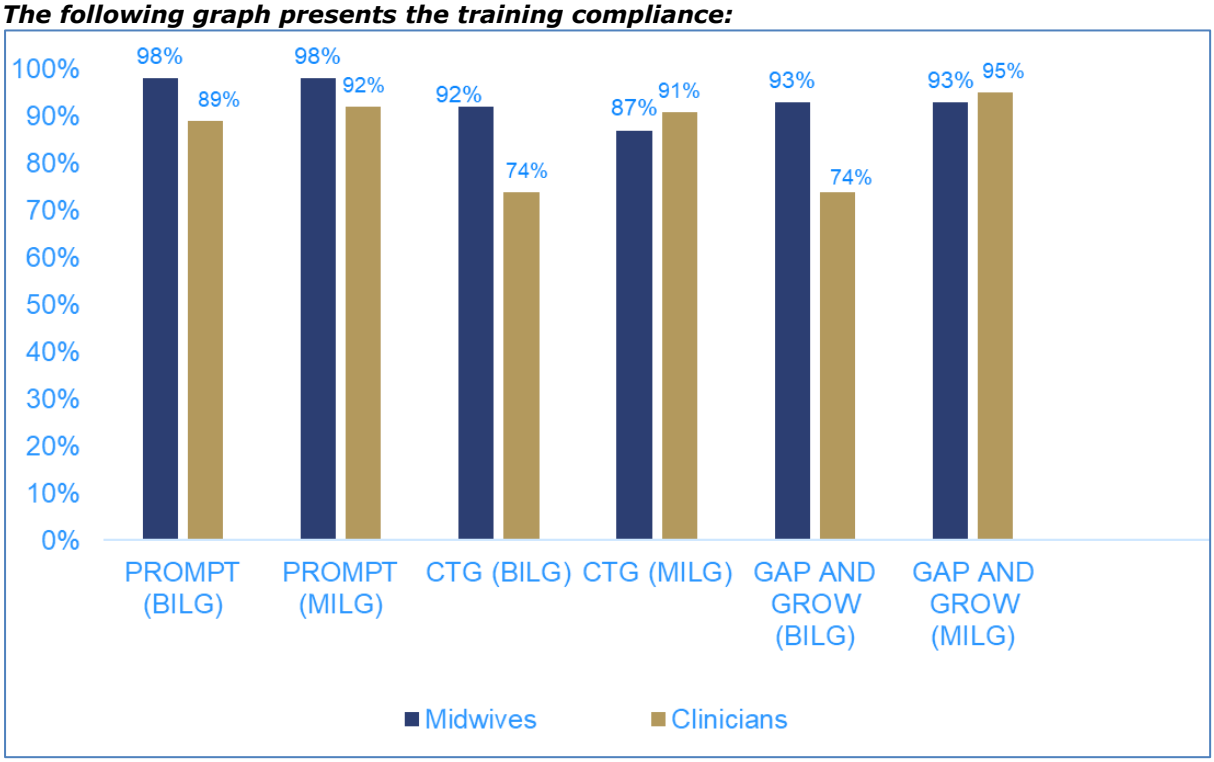


'low harm' showing a decrease and moderate harm and above a slight increase with one severe case at PCH. The process for handling cases is that an SBAR is raised; with a MDT review on a

Wednesday and further scrutiny on a Friday in the senior MDT. Actions are allocated on the Datix system and once complete the incidents are finally approved by the Senior Midwifery staff within the clinical area.

Training compliance – December 2022

The following graph presents the training compliance:



Note: A number of staff from PCH acute had been pulled clinically from M+S training scheduled for 2/12/22 which will inadvertently affect the compliance figures in the December report. Again, reasons for this are due to sickness levels and has been escalated to the senior team.
There has also been a significant number of staff sickness/shortages in all areas.
Compliance is reviewed/monitored on a monthly basis, staff who are not complaint are contacted by the training team to ensure their compliance. If still not compliant, this is escalated to the Care Group medical director to ensure all the staff are compliant with CTG and Gap and Grow training. Rota is adjusted to allow the medical staff to complete any required training.

National Maternity/Neonatal safety programme

This is a national short-term improvement programme across all HB's led by Improvement Cymru with the aim to report on findings by 31st March 2023; followed by a plan for improvements. The following is the progress to date:

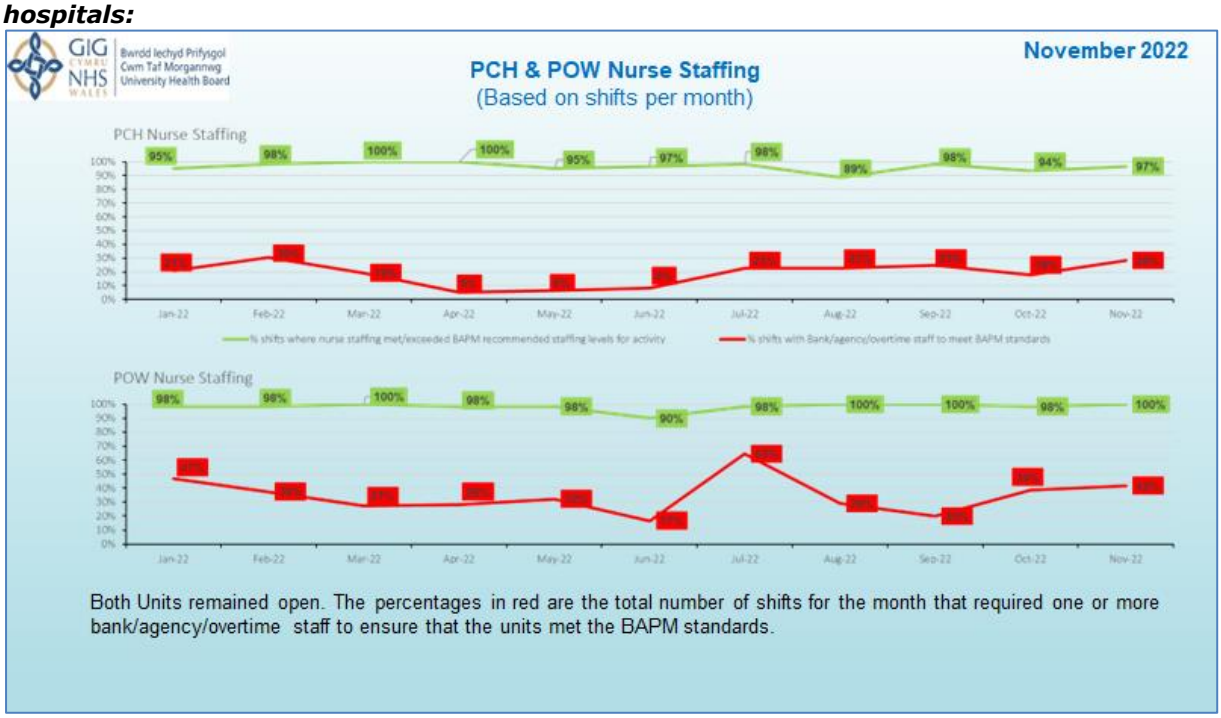
- **Mat/Neo safety officers** for CTM in post – collate thematic responses onto diagnostic tool
- **Phase 1** – collection of thematic responses in progress/interim report due 30/12/22
- **Phase 2** - collection of data/final report to be published 14/2/2023
- **Site visit** by senior leads from Improvement Cymru on 13/1/2023

Note: Series of meetings are in place between the Mat/Neo safety team and the team on shop floor. There is meeting in place between the Care group/Exec team and the Mat/Neo team to discuss the collaboration required to ensure delivery of the aims of the project.

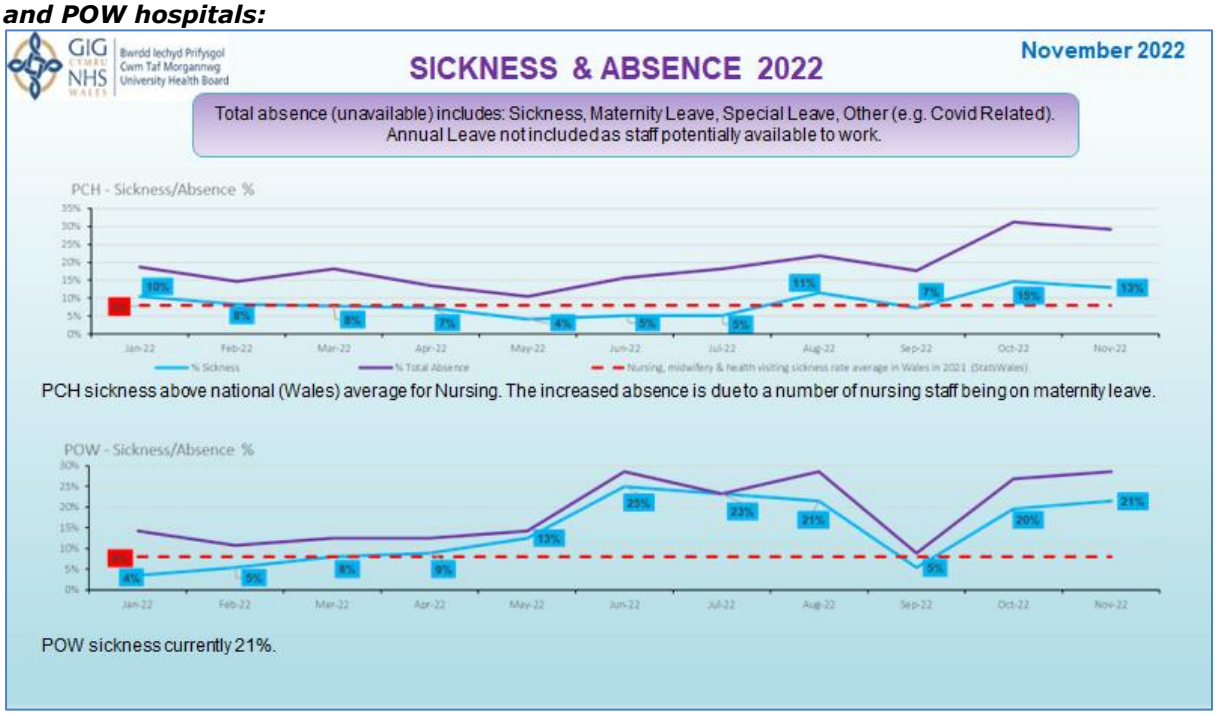
Workforce

Neonatal – November 2022

The following graph presents the Neonatal staffing levels and the bank/agency/overtime to meet BAPM standards in CTM across both PCH and POW hospitals:



The following graph shows the Neonatal sickness and absence levels in CTM across PCH and POW hospitals:



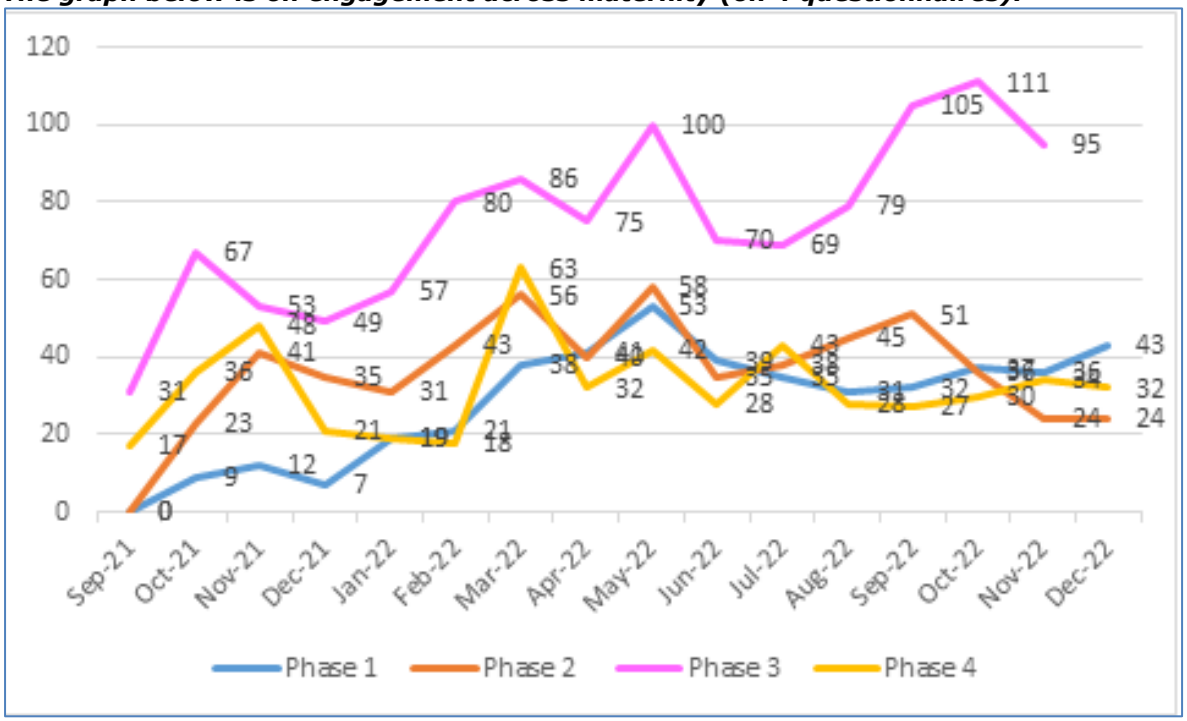
PREMS (patient recorded outcome measures) - Maternity

The following table provides no. of women/details on the different phases when questionnaires are sent out from 13th Sept to 31st Dec 22:

Phase	Type	No. of questionnaires sent
Phase 1	After anomaly USS	476
Phase 2	At 37 weeks	585
Phase 3	14 days post-birth	1193
Phase 4	12 weeks post-birth	521

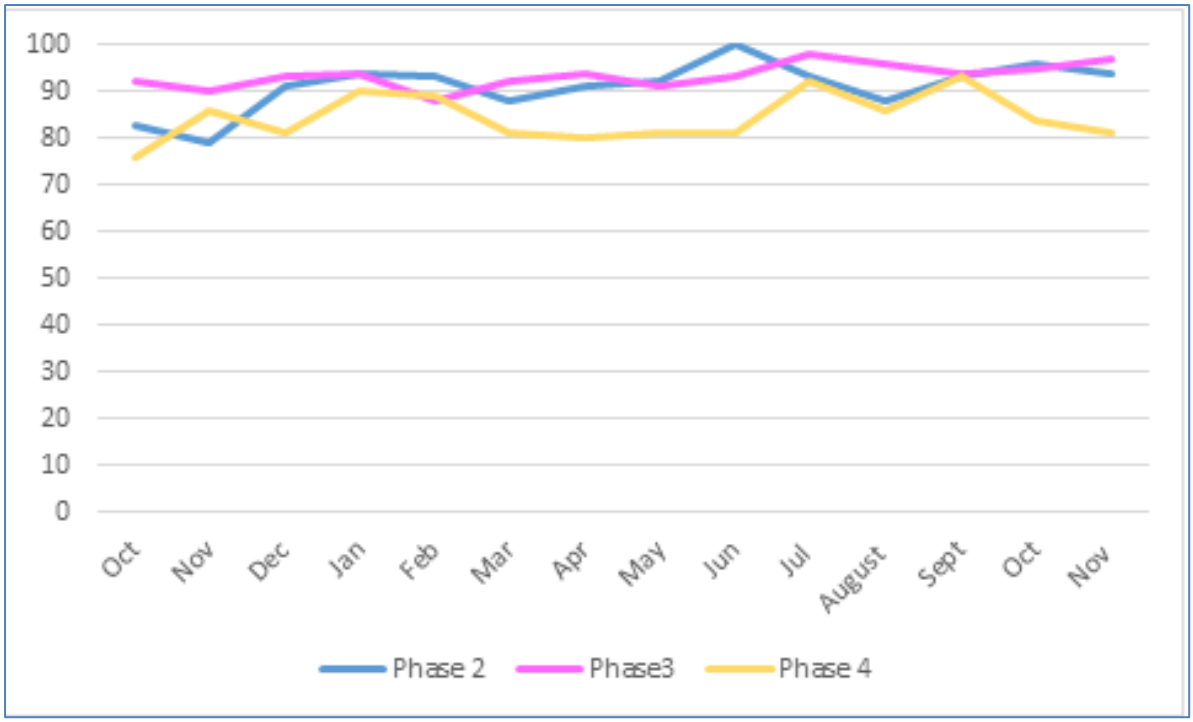
Overall, 25% response rate to Phase 2. Note: Phase 2 completed by those who have had their anomaly USS within the service; we continue to engage with our families to encourage completion of questionnaires.

The graph below is on engagement across maternity (on 4 questionnaires):



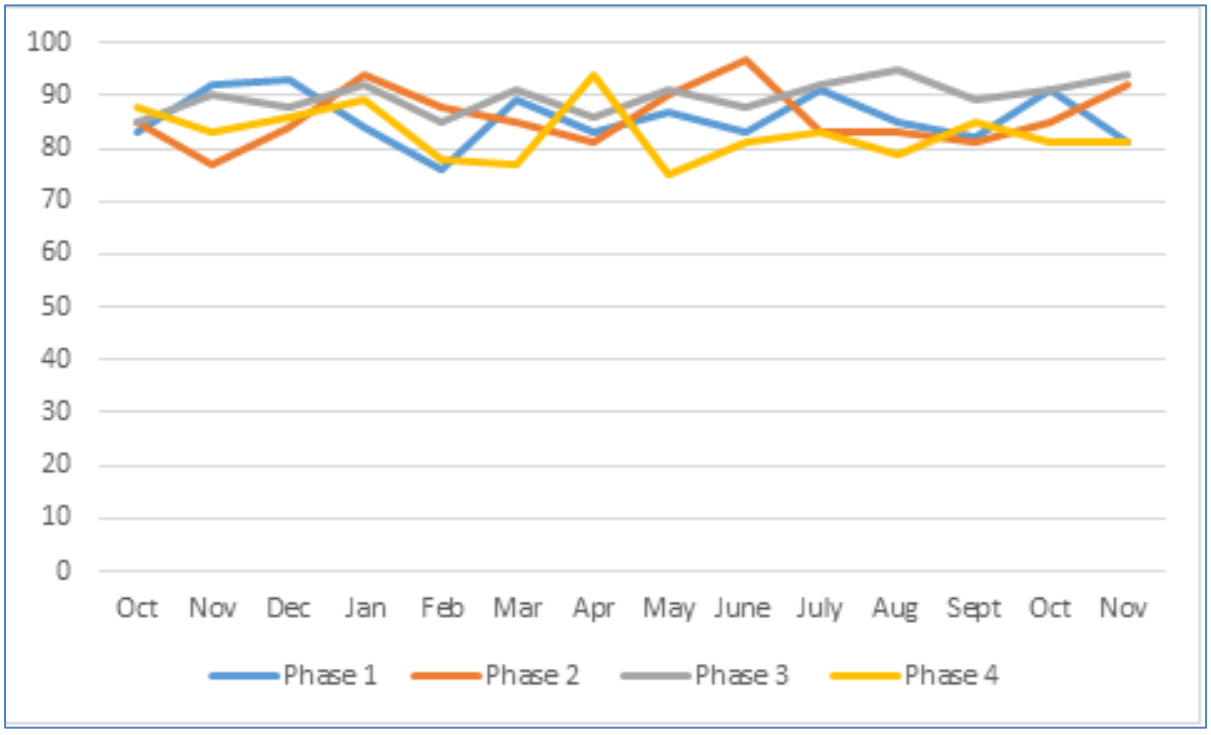
Note: For context, 4 questionnaires i.e. phases are sent out to women throughout pregnancy and post-birth (1st after anomaly scan, 2nd around 37 weeks, 3rd at 14 days post-birth and 4th at 12 weeks post-birth) and as presented above, there's good engagement.

The chart below is for the question 'Thinking about your care, have you been treated with dignity and respect'?:



Phase 4 asks specifically about pregnancy/post-birth experience as an overall so is likely why this is reflected a little lower.

The chart below is for the question 'Thinking about you care, were you treated with kindness and understanding'?:



Again, phase 4 picks up the pregnancy/post-birth as a whole, therefore is reflected lower.

Table below presents key themes (relating to areas of concern/requiring improvement) and how we've approached to make improvements:

Theme – requiring improvement	Improvement
Being able to contact community midwives	Implementation of community team phones, communication team supporting work to ensure all women have appropriate contact numbers, and the triage project for women contacting us with pregnancy concerns.
Partner visiting/involvement	Experience data has increased a lot with reducing visiting restrictions, but remains very low on ward areas, and we have discussed and considered further changes we can make safely in view of Covid/RSV and other IP&C restrictions
Women making choices which are right for them	Commissioning Birth Rights training for clinicians around choice and consent, and supporting individualised care planning.
Women making informed decisions/having appropriate information and explanations around induction of labour	An Improvement working group for all areas of induction of labour has been set up to consider strengthening the information we have available for women.

Neonatal engagement – progress update

With the appointment of an Engagement Lead in May 2022 and the Neonatal engagement strategy which was launched in July 2022, various methods of engagement are in place such as social media i.e. QR code questionnaire; Facebook; twitter; engagement forum which involved families and staff; awareness days; face to face; patient stories; you said we did etc. Also a monthly engagement forum and planned events such as Christmas party for families (30 attendees) and staff.

The following table provides an update on the Neonatal engagement social media reach:

Social media	No of members and response rates
Cwtch Facebook group	401 members (27 new members this quarter)
PCH SCBU Merthyr Facebook group	568 members (28 new)
Average post reach	300-400 views (increased from last quarter)
Average response	10- 30 likes or comments
Twitter	350 followers (37 new followers)

The following table presents the no. of compliments/complaints received:

Compliments	PCH	POW
Thank you, cards, received	25	20
Social Media compliments	101	60
Comments book on wards	0	1
Complaints		
On the spot	0	2
Formal	1	0

Neonatal are in the process of setting up an electronic questionnaire on CIVICA like Maternity services i.e., PREMS to be launched in February 2023 but in the meantime the department have designed a questionnaire via a Microsoft form accessible using a QR code and a paper copy on the wards.

The table below presents the no. of responses between July 22 to December 22:

Site	No. of responses
PCH	30
POW	46

Note: 98%of the respondents were white British and 7 were of the male gender

The following table demonstrates the 'fundamentals of care' and what we do well?

What we continue to do well?	% of responses
Felt they were always or usually fully informed about care	88%
Always or usually received an update from their doctor	90.5%
Felt that they were always or usually treated with dignity and respect	90.5%
Always or usually felt encouraged to participate in baby's care	92%
Felt they were always or usually fully informed about care	88%

The following table identifies 'what we could have done better':

What we could have done better?	% of responses
Felt that they sometimes or never received sufficient info about unit facilities, visiting, support groups	9.5%
Sometimes or never had unrestricted access to their baby	9.5%
Sometimes or never felt able to stay overnight with their baby	15%

Sometimes or never felt that they had access to an area to make drinks and meals or wash and shower	19.5%
Felt that they sometimes or never received sufficient info about unit facilities, visiting, support groups	9.5%

The following table presents re-occurring themes identified from the responses:

Re-occurring themes
• Stress and anxiety experienced during stay • Infant feeding • Access to well-being • Separation

Our aim to continuously improve on these themes

3.0 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.
- **Remaining Neonatal deep dive actions -** delivery
- **Improvements** - are being embedded into business-as-usual practices.
- **Care group service risks as 'high'**: *Maternity Services* – manual handling training; *Neonates* – staffing establishment and infrastructure in POW

4.0 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The progress of the MNIP has demonstrated to Welsh Government the continued improvements in standards of services; resulting in removal of special measures for Maternity.
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 <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	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

RECOMMENDATION

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