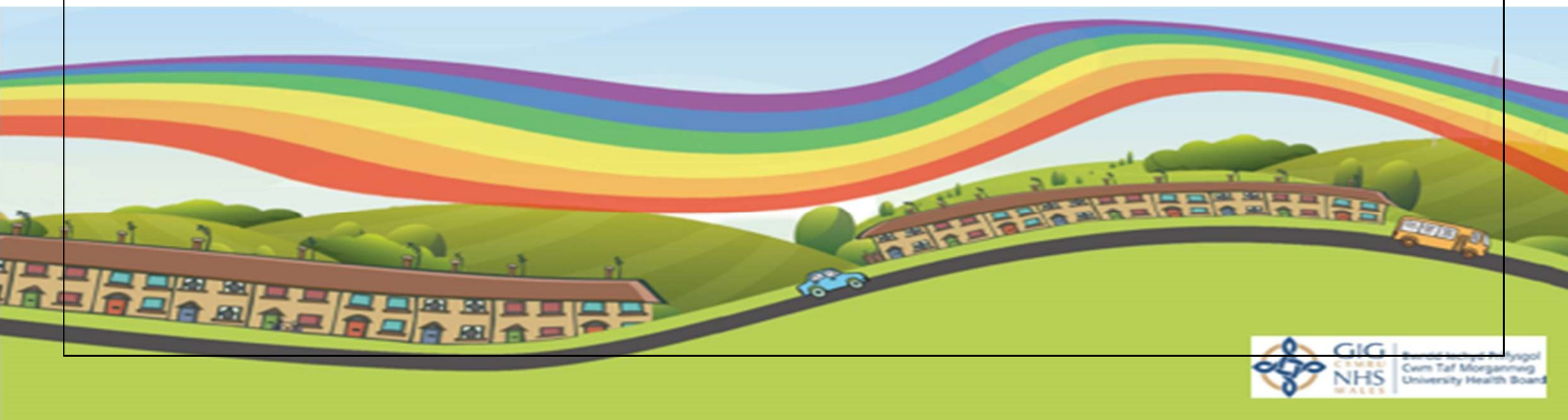
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CWM TAF MORGANNWG UHB RESPONSE TO INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL (IMSOP) NEONATAL SERVICES DEEP DIVE REPORT

February 2022

Written in conjunction with Neonatal and Maternity Services
and the Neonatal and Maternity and Improvement Team



Foreword

The purpose of this report, by Cwm Taf Morgannwg (CTM) University Health Board, is to provide a response to the findings identified by the neonatal team of the Independent Maternity Services Oversight Panel (IMSOP, hereafter referred to as the Panel).

The findings have informed the work that has commenced since the Welsh Government commissioned an independent review of Maternity Services by the Royal College of Obstetrics and Gynaecologists (RCOG) and the Royal College of Midwives (RCM). The Royal College's report in April 2019 identified a number of serious concerns relating to the Maternity Services at CTM and included Neonatal Services.

Our Health Board has produced a number of response reports since January 2021, with the focus on our Maternity Services and the care of mothers and babies. These include responses to the Panel's thematic reports for the Maternal Mortality and Morbidity and Stillbirth categories. A third thematic report is anticipated later this year, focusing on the Neonatal category.

In this response, we concentrate on the care of infants, and the experiences of our families from a Neonatal Services perspective.

Our Health Board understands that this report may, for many families, be difficult and upsetting to read. We would like to reassure our families and communities that we are committed to providing the best possible care to all families who access our services. We hope that this report demonstrates the learning and the improvements we have made, and that we will continue to make.

We would like to extend our apologies to any family affected by any experience of care that was not of the high standard that we aspire to. We are truly sorry, and continue to strive towards providing the very best care for all those who use our services.

Paul Mears, CEO

Emrys Elias, Chair

Table of Contents

1.0 Introduction and 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.The focus and objectives of the Deep Dive were agreed by our Health Board and Welsh Government to ensure that our Service was:

- **Safe and effective**
- **Well led and well managed**
- **Focused on providing a quality experience for women and families**
- **Integrated with Maternity Services to provide a seamless service for women and babies**
- **Effectively integrated within the wider Wales Maternity and Neonatal Network**
- **Fit for purpose and sustainable in the longer term.**

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 has now been published with 43 recommendations, grouped into the following seven key areas or 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**

This report summarises the learning undertaken by our Health Board in relation to those recommendations, based on the seven themes, and highlights the improvements we have made and continue to make.

2. What the Panel Found: The findings and our responses

The Neonatal Deep Dive review report identifies recommendations summarised into seven key themes. The Report, and its recommendations, incorporate those concerns previously identified within the Escalation of Concerns report published by the Panel in August 2021.

This report, therefore, provides the following information :

- A summary of the key concerns and issues as identifed by the Panel within the seven themes.

- Examples of the work we have undertaken to make the required improvements, as identifed within both the Escalation of Concerns Report (August 2021) and the Deep Dive Report to which this is a response.

- Ongoing and future improvements that are we committed to, to ensure long term sustainable change.

It should be noted that whilst the Deep Dive review focused on our Neonatal Unit at PCH, the programme of improvements includes neonatal colleagues and teams at our Princess of Wales (POW) Unit in Bridgend. We will ensure that we have equitable approaches that reflect neonatal standards on both of our units.

We hope that the following information helps to reassure our families and communities that we are working hard to respond to the recommendations outlined in the review, as we aspire to a high quality service for all of our families.

3. What the Panel reported in the Deep Dive review and our responses

THEME 1: FAMILY ENGAGEMENT

The Panel identified that we were not consistent in our support to families and that we needed to improve in the following areas:

1. Communication and information to families
2. Involvement of parents and carers in decisions about their infants' care
3. Variability and inconsistency in service
4. Emotional support provided for families
5. Breastfeeding support
6. Discharge and support at home
7. Separation from baby
8. Listening and responding to Concerns

How have we responded?

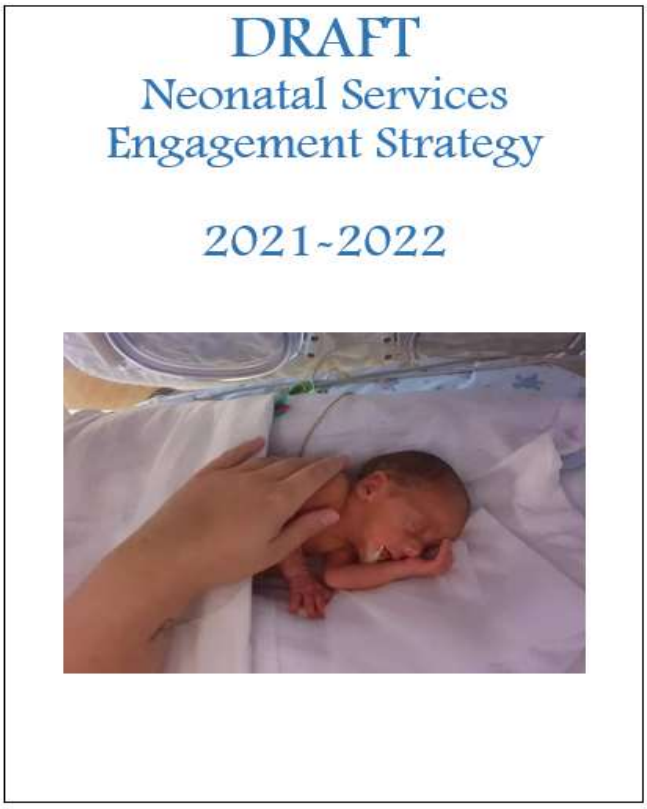
A NEONATAL FAMILY ENGAGEMENT LEAD

We have created a new dedicated Neonatal Nurse, Engagement lead post. This post holder will lead on family engagement and develop family-focused services across both of our units. Specific areas of work that the Engagement Nurse will lead on include the development of a Neonatal Parent Carer Forum, where parents and carers can influence this work.

We are currently advertising this important role to join our Neonatal Team with the hope of recruiting by Easter 2022.

We have revised our documentation to facilitate better recording of communication with and information shared with families. This has been done in collaboration with a member of the Panel.

OUR FAMILY ENGAGEMENT STRATEGY



Our draft Neonatal Services Engagement Strategy shapes our plans for the engagement of families. As this plan is finalised, supported by our new Engagement Lead Nurse, we will work with families to ensure that we have a comprehensive range of ways and channels to engage with our families and communities. This will be linked with the themes identified by the Panel and will include the mechanisms by which these will be addressed in more detail.

FAMILY ENGAGEMENT AND INFANT FEEDING

We are determined to improve our support for women who want to breastfeed, so we are reviewing the support we provide to our families to really help them make the best choice for them. Our Infant Feeding Leads Natalie and Geraldine demonstrate our commitment to supporting families with infant feeding.

"Ensuring that parents are able to have close and loving relationships with their baby, have breastfeeding support, and are valued as partners in care, is paramount on our Neonatal Units. Our role is to promote the benefits of breastfeeding and provide support to families. We also ensure that neonatal staff are updated by providing regular training and auditing of skills and knowledge. During 2022 our family engagement work will include more detailed discussions with families about infant feeding to really make sure that we support families the best way possible."

INNOVATIVE PRACTICE

There are many examples of innovative approaches, initiated and implemented by our teams. A good example of this is the 'end of treatment bell'; a symbol of hope for families who find themselves on this unexpected

and emotionally challenging journey. The introduction of the bell offers families a positive celebration upon discharge home.

FUTURE ENGAGEMENT PLANS: PSYCHOLOGY SUPPORT

During 2022, a programme of support for our families will be led by a Consultant Clinical Psychologist, who has been funded to pilot an initiative centred around psychological support for families on our Neonatal Units.

The aim will be to provide psychological support and advice to families and carers during the time that their infant stays on the Unit.

SEPERATION FROM BABIES

We are using ATAIN data to review and hopefully prevent term admissions. The objective of this programme of work is to avoid the potential for harm leading to the separation of mother and baby.

LISTENING AND RESPONDING TO CONCERNS

The NHS (Wales) Redress Measure 2008 and the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, guide the way in which our Health Board responds to patient concerns and feedback. Our Neonatal Units are supported in this by the Integrated Locality Group Concerns Teams.

THEME 2: GOVERNANCE ASSURANCE AND ACCOUNTABILITY

The Panel found the following issues to be of concern:

1. The systems and governance processes did not clearly support the demonstration of either safe and effective care, or indicate risks or concerns
2. The Neonatal Service information about infant care and improvements, did not demonstrate our learning from incidents through to the Health Board
3. Our clinical audit programme was not well established
4. Capacity
5. Service Integration
6. Culture

How have we responded?

ESTABLISHING GOOD GOVERNANCE

We have already taken a range of measures to ensure that our Neonatal Service is able to demonstrate good practice, high quality care and service improvements. We are also sharing lessons learned and examples of practice where further improvement is needed.

For example:

Clinical Expertise:

We have recruited a highly experienced specialist Neonatologist, with responsibility for improving governance within our Neonatal Units, and to help support audit projects across our Health Board.

The Neonatologist now chairs our cross Health Board Neonatal Forum, where medical and nursing staff come together to review service issues and

agree service developments. There are a range of clinical Neonatal meetings that report into the Neonatal Forum to support this work

The Neonatal Forum reports formally to the Senior Team within our wider Children's Services, and ultimately through to the Board to provide assurance at that level.

FUTURE IMPROVEMENT PLANS

Our Health Board is currently developing an Improved Assurance Framework and Board for Maternity and Neonatal Services to be implemented during 2022. This will refresh our processes for monitoring performance, and the safety and effectiveness of the Service, and report these through lines of accountability to our CTM Board.

Capacity:

We are grateful to the Panel for acknowledging the impact of the pandemic on our ability to progress the actions required, both in terms of capacity within the Improvement Team, and the capacity of clinicians to be responsive to the demands of the improvement work. This has, in part, been addressed in the workforce response below.

Integrated Working:

As also addressed elsewhere in this response, our Neonatal and Maternity Teams have a revised and structured programme of meetings, training and audits to enhance cooperative and effective partnerships and support learning and service developments.

Culture:

The Panel has acknowledged the work done by our wider Health Board in terms of organisational culture, including our Values and Behaviours programme. This is further supported by a new staff appraisal process, and a programme for aspiring and established managers; "Aspire, Ignite, Inspire". This builds on the work done as a result of the Audit Wales and HIW report, 'An overview of Quality Governance Arrangements at Cwm Taf

Morgannwg University Health Board: A summary of progress made against recommendations May 2021'.

Specific to Neonatal service provision is the current development of a culture framework across both Maternity and Neonates. This will further build upon existing work and support staff to lead and manage change.

THEME 3: NEONATAL SERVICE WORKFORCE

The Panel identified a number of issues and concerns as well as opportunities to enhance our workforce as well as specific areas that needed strengthening.

Within the Medical workforce:
1. Our Doctor rota needs to include a Consultant of the week, with a working pattern from 09:00 - 17:00. All Consultants who cover the Unit on call require a minimum of four Neonatal Service weeks each year.
Within the Nursing workforce:
2. Previously, our Senior Nurse roles for Neonates also included roles in Children's Services. There should be a Senior Nurse solely dedicated for Neonatal Services. 3. We have a traditional workforce model with no clear career progression and with just one Advanced Neonatal Nurse Practitioner. This is not considered enough, and we do not have a Consultant Nurse post. 4. When our Nurses are in charge of the Unit they often have to provide care for babies in addition to their managerial roles. This does not align with national guidelines, which recommend that the Nurse in charge does not have responsibility for an allocated infant. 5. We need to expand our workforce skill set with a rotation of nursing and medical teams to our neighbouring neonatal units such as at the University Hospital of Wales in Cardiff. 6. We do not have Therapists (Allied Health Professionals) for our Neonatal Services, which is not in line with national recommendations.
Training and Progression:

7. Our mandatory training compliance was not sufficient and needed to improve across all staff groups and be undertaken within working hours.

8. Nursing, midwifery and medical Newborn Life Support (NLS) instructors needed to be identified within CTM to support NLS local training and simulation training.

9. A specific nurse teaching programme should be developed, linking into network nurse teaching.

10. Our nursing teams do not have a formalised system for clinical supervision.

How have we responded?

MEDICAL WORKFORCE

Leadership and clinical oversight:

We have recently recruited additional Consultants and currently have no vacancies for Consultant posts.

We now have a dedicated Consultant of the week who is available specifically for the Neonatal Unit at PCH.

Revised rotas now ensure that Consultants provide on-call cover for at least four weeks per year.

NURSING AND THERAPIES (Allied Health Professionals) WORKFORCE

Leadership:

A Senior Nurse has been appointed solely to oversee the Neonatal Unit at PCH, providing additional and focused senior nursing support and leadership.

Training:

We have developed a rotational programme with the University Hospital of Wales. The aim is that nurses from both of the CTM Neonatal Units will

spend time working and developing their professional skills at this much larger specialist unit. The rotation is planned to commence as soon as staffing pressures, associated with the increase in COVID cases, has eased.

Workforce models:

A business case is under development by the Neonatal Teams, for internal approval, which allows Neonatal Services to develop a new workforce model, incorporating the additional Deep Dive recommendations for Nursing and Therapies.

Supporting the Teams:

A supervision model is currently being developed, with a view to offering this to all staff during the next three months. This will provide stronger professional support to staff on the unit.

Leanne Richards, our Lead Neonatal Nurse, is passionate about providing the best possible neonatal care and commented:

"We are committed to ensuring we have the right staffing levels for our units to ensure that Neonatal Teams are best placed to provide excellent care that mirrors neonatal standards. We are working through the Panel's recommendations for our multi-disciplinary teams on both sites."

THEMES 4 and 6:

NEONATAL UNIT SAFETY and FUNCTIONALITY

The concerns identified about unit safety and functionality have been summarised together due to their similarity and include:

1. A lack of evidence that incidents were robustly reviewed, and that cultural and human factors were included.
2. Maternity and Neonatal Services were reported as not working together as effectively as they should.
3. Governance and assurance processes across Maternity and Neonatal Services were not shared.

How have we responded?

REVISED GOVERNANCE ARRANGEMENTS

Policies and standards:

We have reviewed and updated all of our clinical policies to ensure they meet the needs of a modern neonatal unit

Meetings and sharing good practice:

Neonatal and Maternity Services have reviewed and revised formal joint meetings with senior clinical and management teams in attendance. The meetings now reflect good governance with opportunities to review concerns, formulate action plans and lead and direct any learning.

There are now well established Maternity and Neonatal meetings to review clinical issues and incidents including ATAIN (Avoiding Term Admissions in the Neonatal unit) and PMRT (Perinatal Mortality Review Tool), which all Neonatal Services are required to comply with, as well as Morbidity and Mortality meetings.

Audits and learning:

There is a joint Maternity and Neonatal audit programme for 2022, which will support our teams to review and challenge practice as well as share examples of clinical excellence.

THEME 5: ALL WALES AND NATIONAL REPORTING

The Panel identified that available neonatal specific data was not being used to inform practice; the data quality was poor and we did not have a systematic way of capturing and reporting data.

How have we responded?

A Neonatal Data Officer, who is also an experienced Neonatal Nurse, was appointed to lead this area of work in June 2021. This has led to the development of a Neonatal Dashboard, which reflects all-Wales Neonatal Standards. We are continuing to refine the dashboard and we are now able to use this to monitor performance and the safety and effectiveness of the Service.

Ryan O'Dell the Neonatal Data office advises of the importance of this work:

"Developing a Neonatal dashboard has been key to demonstrating many aspects of neonatal care. I have worked with the lead Neonatal Doctors and Nurses within the Service to ensure that we can describe a wide range of information using the dashboard. This includes everything from the reasons infants are admitted to our Units and their subsequent care, through to Neonatal audit criteria and our staffing levels. The data, when collected and analysed, plays an important role in improving the quality of care we provide within our Service. The aim is to use this information to share with our families and our teams to help inform our service models."

THEME 7: CLINICAL CASE ASSESSMENTS

The Panel identified the following issues and concerns regarding clinical activity:

1. We needed to provide our Doctors with additional support from tertiary neonatal services.
2. We need to have better escalation processes in place to support early recognition of the need to refer infants to specialist tertiary units.
3. Our prescribing standards were poor at times and we should have dedicated Neonatal Pharmacy support to help teams improve this.
4. Management of certain conditions e.g. (hypoxic ischaemic encephalopathy and the management with therapeutic hypothermia) was not always in line with national best practice frameworks.
5. Standards of the assessment and reporting of x-rays were considered poor in some cases.
6. Our documentation and record keeping was not always in incompliance with GMC/NMC guidance and there was not routine oversight of discharge summaries by a Senior Doctor.
7. There were high number of unplanned extubations, which needed to be urgently reviewed.
8. Risk Management
9. Communication with families

How have we responded?

MEDICAL SUPPORT

Specialist Expertise:

We have established arrangements with a Tertiary Unit who provide Doctors on the Neonatal Unit with timely advice about care of babies when needed. Beginning in February 2022 the Tertiary Unit has agreed to support the local units by inviting our Consultants to visit them to facilitate learning and maintain necessary skills.

- We have a trigger list to support decision making for Doctors around the need to contact the Tertiary Unit.

- The All-Wales Maternity and Neonatal Network has a dedicated transport team, CHANTS (Cymru inter-Hospital Acute. Neonatal Transfer Service). The team is committed to providing safe transfer of babies requiring intensive care and specialist ongoing care, according to clinical requirements. They operate 24/7, supporting our teams when escalation of care is required from tertiary centres.

- All Wales Neonatal guidelines have been introduced within both units to ensure equable care for infants, who require therapeutic hypothermia (cooling of infants).

CLINICAL IMPROVEMENTS

Quality Improvement:

There is a programme of continuous quality improvement work underway on both units, with a key focus on avoiding infants being admitted when they are born full-term. This is referred to as ATAIN (Avoiding Term Admissions into Neonatal Units) and includes a series of projects, which assess if an infant's admission to the Neonatal Unit could have been avoided. The aim being to decrease admissions and increase the number of babies staying with their families on postnatal wards.

Examples of this work include:

- A Quality Improvement project, which has facilitated progress with *therapeutic hypothermia*. This is the process when a baby's temperature is reduced carefully with the correct equipment to help protect the baby's brain prior to transfer to a tertiary centre to continue treatment. This links to ATAIN's core priorities.

- A programme of work has also commenced to reduce the number of infants admitted for *hypoglycaemia* (low blood sugars). The numbers of infants being admitted for low blood sugars should be reduced through the introduction of our new Hypoglycaemia Pathway, which will help keep babies with their mothers on postnatal wards, reducing admissions to the neonatal units. This has required additional training and the purchase of new equipment to facilitate the pathway. This links to ATAIN's core priorities.

- There has been work to address unplanned extubations with extra training for securing of the endo-tracheal (breathing) tube, which involved the purchase of new tape, and nursing champions to lead the training programme. This is an example of a risk which was identified through the Panel's reviews which has now been addressed and resolved.

PRESCRIBING AND PHARMACY SUPPORT

We have recruited a Pharmacist exclusively for Neonatal Services, who commenced the role in December 2021. The post holder has already led the development of new standards and guidance for our teams and will be developing an audit of prescribing standards and a training programme during 2022. Rebecca Owen said:

"The role of a Pharmacist is to ensure the safe and effective use of medicines for all patients. I will assist the Neonatal Team in optimising medication choice and dosing regimens, ensuring appropriate monitoring occurs to improve safety around medicine use in neonates. My role also involves training and supporting neonatal staff to ensure medicines are appropriately prescribed and administered. I will also be involved in neonatal clinical governance and provide expert knowledge to help improve safety of medicines in this vulnerable patient group."

DOCUMENTATION AND RECORD KEEPING

To ensure that we improve our documentation standards, we have established a small working group of Senior Doctors and Neonatal Nurses who, during 2021, have undertaken the following:

- Audited neonatal records at both of our units.
- Re-issued to our teams the Nursing Midwifery council (NMC) and General Medical council (GMC) requirements for record keeping.
- Developed a new suite of records for use on both of our units.

- Developed new Neonatal Standards, which will be launched in February with a new training programme.
- Agreed an audit programme for reviewing standards of documentation and record keeping for 2022.

7.5 RADIOLOGY

To facilitate timely reporting of x-rays, provide high quality and prompt neonatal imaging reporting and support to clinical teams, the Radiology Team has established a range of measures:

- Access to specialist tertiary neonatal radiology support is now being used to enhance our radiology services.
- Neonatal clinical radiological management meetings are available virtually and provide a platform for clinical review and learning and specialist paediatric radiological opinion.
- An audit programme will commence in 2022 to ensure standardisation and peer review of neonatal x-ray reporting.

Dr David Deekollu is a Consultant Paediatrician and the Clinical Service Director for Children and Young people services at Prince Charles Hospital, and is the lead for the clinical aspect of the Neonatal Improvement Programme. Dr Deekollu said:

"The Paediatric and Neonatal Team at Prince Charles Hospital is committed to delivering high quality care for the babies born locally, ensuring good outcomes, positive family experiences and avoiding harm. Specific areas of service improvement were identified and, in my role as the Clinical Service Director, I have been engaging closely with senior Health Board leadership, the Neonatal Improvement Team and the Clinical Team on the ground to achieve the same. I am pleased with the recent progress we have made in expanding our neonatal medical and nursing workforce, strengthening our

internal neonatal governance processes and joint working with the maternity team. This is an ongoing journey of continuous care improvement to our patients and their families."

FUTURE IMPOVEMENTS AND CTM2030

As a part of our continuous improvement work, we will support families to make the best possible health choices, and are developing approaches to engaging with our families.

Jane O'Kane,
Director
STARTING WELL programme

"As part of our strategy CTM 2030, our Health Board has embarked on a population-based health approach, with prevention of ill health and sustainable health improvements as key.

"From an early years perspective, a programme of work is being developed that will prioritise activity relating to need, and will aim to fit together with the socioeconomic factors relating to ill health and poverty.

"Areas for prioritisation include developing a preconception strategy that raises awareness and understanding of preconception health, to supporting families with a range of needs. Planned work will review current models and build future life-course interventions pathways and services."