INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL

Cwm Taf Morgannwg University Health Board

Quarterly Progress Report
Executive Summary
Spring 2020

The Independent Panel was established by Welsh Government in response to the findings of an independent review of maternity services in the former Cwm Taf University Health Board

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FOREWORD

On 30 April 2019, following the publication of a review conducted jointly by the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, the Minister for Health and Social Services announced that he was placing maternity services in the former Cwm Taf University Health Board in ‘Special Measures’.

As part of a package of measures designed to support his intervention, the Minister appointed an independent panel to provide the oversight which is necessary to ensure that Cwm Taf Morgannwg University Health Board addresses the failings identified by the Royal Colleges in a timely, open and transparent manner which places the women and families affected by the review at the heart of the process.

The Panel is currently required to report progress to the Minister on a quarterly basis. This report, the third to be published to date, covers the period of January, February and March 2020.

Mick Giannasi (Chair)

Cath Broderick (Lay Member)

Alan Cameron (Obstetric Lead)

Christine Bell (Midwifery Lead)

Cwm Taf Morgannwg University Health Board
Independent Maternity Services Oversight Panel

Mick Giannasi (Chair) is the Chair of Social Care Wales. He has extensive senior leadership experience and was formerly the Chair of the Board of the Welsh Ambulance Service NHS Trust, a Welsh Government Commissioner for Isle of Anglesey County Council and the Chief Constable of Gwent Police.

Cath Broderick (Lay Member) is an Honorary Fellow of the Royal College of Obstetricians and Gynaecologists and the author of the 2019 report, *Listening to Women and Families about Maternity Care in Cwm Taf*. She has extensive experience in patient and public engagement and supported the response to the Kirkup Inquiry in Morecambe Bay.

Alan Cameron (Obstetric Lead) has 26 years' experience as a Consultant Obstetrician and has recently been appointed as the National Clinical Lead in Obstetrics and Gynaecology for the Scottish Maternity and Children Quality Improvement Collaborative.

Christine Bell (Midwifery Lead) has over 30 years' experience working as a midwife in England, ten of those as a Head of Midwifery and is a designated Midwifery Assessor with the Royal College of Obstetricians and Gynaecologists.

EXECUTIVE SUMMARY

COVID-19

As the Panel began to draft its Spring 2020 Quarterly Progress Report, the scale and impact of the threat associated with the COVID-19 outbreak was just beginning to emerge. It was also becoming increasingly apparent that the NHS was about to face the most significant challenge it has faced in its 72 year history. For that reason, the Panel took the opportunity to review its working practices in consultation with the Health Board and colleagues in the Welsh Government.

Childbirth will continue regardless of restrictions elsewhere in our lives and the safety and welfare of mothers and their babies remains as important in these difficult times as it ever has been. As such, it was agreed that the Panel should continue to provide a measured degree of oversight and support to the Health Board's improvement journey, albeit much reduced during this period.

However, the safety and welfare of the public, the NHS workforce and those the Panel works with is paramount. Consequently, adjustments will need to be made to reflect government advice around social distancing and restrictions on travel. Most importantly, the Health Board needs space to get on with the vital task of preparing for and responding to the increased demands which will inevitably be placed upon it.

In the short term, the Panel is looking at ways in which it can continue to discharge its terms of reference in a proportionate and risk-assessed way by reducing the administrative burden on the Health Board and optimising the use of home working, video conferencing and other more interactive communication tools like webinars and live blogging.

Women and their families lie at the heart of the improvement process and the Panel will work in the coming weeks to find different ways of ensuring that the important two-way conversation which has been started can continue. The Panel's clinical review work, which has now started in earnest, will remain a priority, albeit that the pace of progress may be impacted if independent review team members are called up into frontline operations.

A more detailed statement setting out how the Panel is responding to the current situation and the principles on which it has based its decisions is attached at *'Appendix I'*.

SUMMARY OF EARLY PROGRESS

When the Panel last reported in January 2020, it concluded that the Health Board was making good progress in addressing the Royal Colleges' recommendations and it was cautiously optimistic that longer-term sustainable improvement in maternity services would be delivered as the programme of work matured.

In particular, there was evidence of incremental progress against the 79 actions set out in the Maternity Improvement Plan and clear indications, supported by information from a range of internal and external sources that the service was improving more generally.

That improvement could be seen, not only in terms of the safety and quality of the care being provided, but also in the better experiences of the women and families using the service and in the way in which the service was being managed, led and governed.

The Panel reported that the foundations for continued improvement were now firmly in place; effective leadership, appropriate programme management arrangements, clear lines of governance and accountability and a genuine commitment to deliver change at Board and senior leadership levels. The Health Board was working collaboratively with the Panel and other stakeholders to deliver its Maternity Improvement Plan[1] within an environment of scrutiny and challenge.

The Health Board had also recognised that governance issues which had been identified extended beyond maternity services and was in the early stages of delivering a wider organisational development plan, focusing on leadership development and cultural change.

Although progress was undoubtedly being made, the Panel reported that there was still much to be done and called for an increase in pace, cohesion and administrative discipline. There were also issues, in particular the ineffective management of complaints and concerns, which were impacting on public confidence and needed to be addressed urgently at an organisational level.

The Panel identified a number of areas where it expected to see progress by the time it next reported, including further development of the Integrated Performance Assessment and Assurance Framework and further development of the Maternity Improvement Plan to include clearer milestones and targets.

Those issues and a summary of the progress which has been made against them are set out in more detail in Section 7 of the report.

FURTHER PROGRESS AGAINST THE MATERNITY IMPROVEMENT PLAN

Building on those solid foundations, the Panel is pleased to report that the Health Board has made **further incremental progress** during January, February and March 2020.

As a result, the Panel believes that the Health Board is now **firmly on track**, not only to deliver against the Royal Colleges' recommendations, but also, in time, to deliver a maternity service which they, their staff and their communities can be proud of.

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[1] The Maternity Improvement Plan is a consolidated action plan which contains 79 actions which address the seventy recommendations emerging from the Royal Colleges' review and nine other recommendations which emerged from associated internal reviews.

That is not to suggest that the job is done and further challenges and obstacles will undoubtedly materialise along the way. However, in the Panel's opinion, the Health Board now has the right resources, the right mechanisms and the right people in place to deliver the continuous improvement which is necessary to achieve that.

The Panel's main concern at this time of great uncertainty is whether the Health Board will be able to maintain the longer-term focus and commitment that is now needed to build upon the solid platform which has been created. Those concerns, are explored in further detail in Section 7 of the report.

During the period under review, the Panel has assessed evidence which provides them with reasonable assurance that a further 16 recommendations have been delivered since they last reported, bringing the total now completed to 41. This includes the following developments:-

- the bereavement service has been reviewed and improvements have been made to ensure that appropriate support and counselling is available for all families, albeit that a Task and Finish group has now been set up by the 'My Maternity My Way' forum to co-produce further enhancements;

- the maternity Governance and Risk team has now been appropriately resourced to ensure that workloads are manageable and that Datix (a system for recording health and safety related incidents) records are reviewed, graded and actioned in an appropriate and timely manner;

- all Independent Board Members have now been trained in the implications of the Corporate Manslaughter and Corporate Homicide Act 2007 to better understand their role in ensuring the safety of services provided by the Board;

- a mandatory training programme (including training in CTG, PROMPT, GAP and GROW[2]) has been designed and delivered to all medical and midwifery staff and high levels of compliance have been achieved[3].

That means that the Health Board has now delivered over half of the 79 recommendations in the Maternity Improvement Plan with the remainder work in progress.

That is a significant milestone, particularly as many of the recommendations which have been delivered, such as the revised clinical governance framework and the clinical audit programme, are fundamental building blocks for the delivery of others.

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[2] See glossary of terms in Section 11 of the report.

[3] A training plan was designed which would have achieved full compliance by 31 March 2020. However, training was suspended in mid-March due to the COVID-19 response and a small number of medical staff at the Prince Charles Hospital who were due to be trained at the end of March will now receive their training once normality has been restored. There are also a small number of medical staff at Princess of Wales Hospital who have still to complete their training, albeit that falls outside the Panel's terms of reference. Notwithstanding that, the Panel considers that the action which RCOG recommended has been fully delivered.

It is also important to emphasise that although they are not yet ready to be finally signed off, substantial progress has been made against a number of the 38 remaining recommendations. For example:-

- the ‘Maternity Vision’ (a plan which sets out long term strategic aims aligned to the all-Wales Maternity Vision) has been developed and is now out for consultation with a range of stakeholders including women and families representatives;

- the leadership, mindfulness and corporate values training programmes (which are part of the wider organisational development plan) are being rolled out and the level of attendance and participation has been encouraging.

Over the last three months, the Panel has also re-assessed a number of recommendations which were signed off in previous quarters to ensure that progress has been sustained and that change has become embedded in practice. That includes, for example, further checks around consultant availability and response times and confirmation that key members of staff are routinely participating in governance related meetings and events.

In addition, a ‘triangulation’ exercise was undertaken following the publication of the Healthcare Inspectorate Wales (HIW) report of the three-day unannounced inspection at Prince Charles Hospital in November 2019, to provide assurance that the issues which were identified in that report had been addressed.

Despite the obvious progress which has been made, there are a small number of recommendations against which the Panel would have expected to see more progress and these will be the subject of renewed focus in the next period. In particular:-

- whilst the Birthrate Plus® review has confirmed that existing staffing levels are appropriate, the Panel awaits the development of a longer term workforce action plan which shows how those resources will be optimised (for example, by reducing sickness and reducing the use of overtime) and how deployments will be adjusted to reflect changing patterns of demand and new ways of working;

- whilst progress has been made in ensuring that policies, protocols and guidelines are readily available and accessible to staff, a significant number of policies now require review and further updating. A prioritised schedule has been agreed and the Panel will be monitoring its implementation during the next period.

A more detailed assessment of the progress which has been made over the last three months in delivering against the Maternity Improvement Plan and more specifically, against the Royal Colleges’ recommendations, is set out in Section 8 of the report.

OTHER INDICATIONS OF FURTHER IMPROVEMENT

Over the past three months, there has been less external review and inspection activity of the Health Board's maternity and neonatal services than in previous reporting periods. As such, there has been less opportunity to triangulate the Panel's assessment against other forms of evidence.

There is however, softer intelligence which supports the Panel's assessment that services are improving and that this is having a positive impact on the experience of women and families. For example, the twice weekly surveys conducted by the Health Board's Patient Advice and Liaison Service (PALS) have continued to demonstrate consistently high levels of satisfaction from women and families using the services at Prince Charles Hospital.

In every improvement journey there are symbolic events which validate the perception that a corner has been turned; they cannot always be quantified or turned into a performance metric but they do provide a real sense that things are changing for the better. The formal opening of the Tirion Birth Centre at the Royal Glamorgan Hospital on 09 March 2020 was one such event.

Not only are the state-of-the-art facilities designed specifically around the needs of women and their partners, the strong bonds which have been built between the staff and the women who have given birth there are self-evident and powerful. That is in stark contrast to the situation reported by the Royal Colleges just over 12 months earlier.

Since its creation in March 2019, the Tirion Birth Centre has become a hub for women, babies and families and a significant number turned out to join the staff in celebrating its early success. Indeed, the line of parked push chairs and buggies extended a long way down the hospital corridor! Some families spoke passionately in the opening ceremony about the way they had been cared for by staff and there was a palpable sense of pride and shared ownership which was incredibly heart-warming for those members of the Panel who had the privilege of attending.[4]

The Panel acknowledges that in relative terms, Tirion is currently a small but nonetheless important part of overall service provision; however, it is seeing evidence of a similar shift in attitudes and relationships in maternity service settings across the entire Health Board area.

[4] *Due to the implications of COVID-19 on staffing capacity, the decision was taken by the Health Board's Gold Command to temporarily decommission Tirion Birth Centre at Royal Glamorgan Hospital from 19:00 on 19 March 2020 onwards. This situation will be kept under close review. The maternity staff from this unit have since been redeployed to support midwifery services at the other Health Board sites.*

INDEPENDENT CLINICAL REVIEW

When the Panel last reported in January 2020, the first phase of the Clinical Review Programme had just begun in earnest. The multidisciplinary teams of midwives, obstetricians, anaesthetists and neonatologists who are conducting the reviews had been inducted and trained in the use of the designated review tool. A pilot study had also been undertaken in order to 'test' the systems and processes which have been developed and to ensure consistency of approach.

Although steady progress was being made, there was some slippage, largely due to a lack of capacity in the Health Board to support the administrative processes which underpin the programme and a lack of preparedness to provide information and support to the women and families affected. The Panel was also concerned that the self-referral process was taking too long to finalise and there was a lack of rigour around the Health Board's administrative processes which was often resulting in re-work and duplication of effort.

Those issues were raised with the Health Board and in fairness, there was an immediate and positive response. The improvement team was re-organised in early January to provide more focused support to the clinical review process and additional capacity was provided to undertake the redaction of case notes and supporting papers.

In addition, the women and families database, which is critical to effective engagement, has been redeveloped in a more robust format while the self-referral process has also been agreed and signed off.

The new staff coming into the team, in particular the Lead Midwife, have brought new skills and insights to the programme and as a result, the support which is being provided by the Health Board is now more robust, timelier and more efficient. The Panel feels better supported in this regard and as a result, the pace has been stepped up and a significant amount of progress has been made.

In the meantime, three more multidisciplinary clinical review teams have now been recruited, trained and inducted, bringing the number now available to six. This has enabled the second tranche (babies who, sadly, were stillborn) to be commenced and the women whose care is about to be reviewed are being contacted to enable them to tell their story if they wish to do so.

In addition to the recruitment of additional multidisciplinary clinical review teams, a Quality Assurance Team and a Quality Assurance Panel have been established to oversee the individual reviews and to draw out the key themes and issues which will form the basis of reporting back to the Health Board. The Quality Assurance Team will also ensure consistency of approach and ensure that the findings are reported back to women and families in a spirit of openness and transparency.

The COVID-19 outbreak will bring new challenges to the clinical review work and the Panel is having to adjust its working practices accordingly. Although the clinical review methodology has been designed to operate in a virtual environment, it is important to recognise that the pace of progress will be affected if clinical review team members or Health Board support staff are called upon to support front line operations.

A more detailed summary of the further progress which has been made in implementing the Clinical Review Strategy is outlined in Section 4 of the report.

ENGAGEMENT WITH WOMEN AND FAMILIES

When the Panel last reported in January 2020, it concluded that the Health Board was making good progress in improving the way it engages with women and families. The Panel's Lay Member had played a pivotal role in leading and coordinating activities in the initial stages of the improvement process. However, she was now increasingly able to step back into an advisory role with the Health Board taking stronger ownership for the leadership and strategic direction of the engagement and communication element of the Maternity Improvement Plan.

The early progress has been consolidated during the last quarter and the Health Board has made further steps forward which are clearly starting to change the nature and tone of the relationship between the people who use the service and those who currently deliver it.

The initial engagement programme has now been completed with the successful delivery of a third event in Bridgend and there are clear plans emerging for activities over the next 12 months. In the meantime, those who are leading the programme have grown in confidence and ability and are now starting to set their own agenda.

There is still much to do, particularly to ensure that the learning from engagement is reflected in service design and delivery and there are still residual issues about the management of complaints, concerns and feedback. However, in broad terms, the Health Board is in a fundamentally different place than it was a year ago in the way it engages and communicates with women and families.

Following the most recent community engagement event in Bridgend, which was the best attended and most productive yet, one of the mothers who attended wrote:-

> *"I just wanted to thank you (all) for your time and for actually making my thoughts, feelings and opinions feel valued and listened to. It really helped me and lifted my mood. It's the best thing I've done so far in 2020, coming to the session today. Thank you again".*

That view is typical of the views expressed by others and reflects a considerable transition from the experiences of those families who shared their concerns during the Royal Colleges' review.

The ground work had now been completed which has created the conditions for further development in this area. The Health Board has completed its analysis of the feedback which has been gathered from the initial phase of engagement and more detailed plans will emerge during the coming months. These plans will set out how the feedback which has been gathered in the initial phase will begin to drive changes in service design and delivery.

Ultimately, this will need to be reflected in the development of appropriate performance metrics within the Integrated Performance Assessment and Assurance Framework (IPAAF).

Looking ahead, the Panel will be monitoring and supporting the delivery of the 2020/21 Engagement Plan, although expectations will need to be realistic given the impact of the COVID-19 situation on the NHS and on the ability of women and families and partner agencies to participate. There will also be a continued focus on the delivery of the maternity services element of the corporate complaints and concerns action plan, where more work is still required.

A more detailed summary of the progress which has been made in this area and some of the work which remains to be done is outlined in Section 5 of the report.

DEVELOPMENT OF THE IPAAF AND THE MATERNITY IMPROVEMENT PLAN

Both the Panel and the Health Board are fully committed to the Integrated Performance Assessment and Assurance Framework (IPAAF) model. The IPAAF is an important element of the oversight process because it enables performance improvements to be monitored, assessed and reported objectively, based on evidence and outcomes.

It will also, in the longer term, provide the means by which the Health Board will be able to gain the assurance it needs that the maternity and neonatal services it provides are safe and effective, well managed and well lead with a strong focus on the experience of the women and families they care for.

When the Panel reported in January 2020, it expressed disappointment about the pace with which the IPAAF was being developed. There was also a lack of tangible progress in enhancing the existing Maternity Improvement Plan to include clearer milestones, targets and deliverables.

In January, additional resources were brought into the Maternity Improvement Team and there were changes in structure which provided increased capacity and greater focus in key areas.

As a result, the Maternity Improvement Director has been able to focus more time and energy on developmental issues and to her credit, a significant amount of progress has been made in a relatively short period of time.

This culminated in a workshop being held on 09 March where broad agreement was reached about the metrics which will be used to populate the three performance domains of the IPAAF and the methodology which will be used to make reasoned assessments against the various levels within the Maturity Matrix which has been agreed as the basis for reporting progress to Ministers.

Although the IPAAF will still require further refinement and incremental adjustment over the coming months, this represents good progress and the Panel is satisfied that a workable performance assessment and assurance framework is now in place.

The significance of this is that for the first time, the Health Board has now been able to self-assess against the Maturity Matrix and has concluded that the current position is as follows:-

Figure 1: *Maturity Assessment – April 2020*

	LEVEL OF MATURITY				
	Basic	**Early Progress**	**Results**	**Maturity**	**Exemplar**
Safe and Effective Care					
Quality of Women's and Families' Experience					
Quality of Leadership and Management					

The Panel has reviewed the Health Board's rationale for the assessment and agrees with the conclusions which have been reached, i.e. the Health Board now making 'Early Progress' and moving towards 'Results' in each of the three performance domains.

A more detailed explanation of the IPAAF, the Maturity Matrix and the rationale for the assessment is included in Section 6 of the report.

As well as making progress in developing the IPAAF, the Maternity Improvement Plan has also been enhanced to include clear timescales and milestones for delivery. Although the link back to the Royal Colleges' recommendations has been maintained, it is now a plan which is about delivering sustainable improvement over time, rather than simply about ticking off a long and sometimes overlapping list of actions.

A more detailed explanation of how the Maternity Improvement Plan has evolved is included in Section 6 or the report and a copy of the high-level plan showing milestones and timescales is included in *'Appendix G'*.

HEALTH BOARD RESPONSE

Over the past three months, the Health Board has continued to work constructively with the Panel to drive forward the improvement programme and despite all the other challenges which the organisation faces at this time, there remains a genuine sense of ownership at Chair, CEO and Board level. The improvement framework which has been put in place through the Maternity Improvement Board (MIB), the Maternity Improvement Team (MIT) and the three Project Boards continues to evolve and by and large it continues to work well.

There were capacity and capability issues in the MIT in the run up to Christmas 2019 and this was affecting the pace of progress. However, the issues were addressed quickly and positively by the Health Board through a restructuring of the team and bringing in additional capacity, particularly in support of the Clinical Review Programme.

Since the end of January, the MIT has been working at full establishment which has improved administrative efficiency and freed up the capacity of the Improvement Director to focus on developmental issues. This has enabled a number of important pieces of work to be progressed during the quarter, not least:-

- the agreement and sign off of the self-referral process;
- the redevelopment of the women and families database;
- further development of the IPAAF;
- the refresh of the Maternity Improvement Plan;
- the timelier presentation of evidence to the Panel;
- the delivery of another tranche of the RCOG recommendations.

The newly appointed Director of Midwifery took up her post in early January. This is the first time that the senior midwifery post has been offered at Director level and the benefits of that are already becoming apparent. The Director brings with her a wealth of experience and relevant insight which is already resulting in increased momentum, new ideas and a more strategic approach.

The appointment also means that the triumvirate of medical, clinical and managerial leadership is now in place on a substantive basis for the first time since the improvement programme commenced. It is noticeable that the leadership team is now behaving in a more cohesive way and is starting to take control of the improvement agenda with the MIT increasingly taking on a supporting role. That greater ownership is particularly welcomed.

In recent weeks, the Panel has become increasingly aware that it has not paid as much attention to the neonatal service as it has the maternity service.

An invitation has been extended to the Lead Neonatologist to attend the next formal Panel meeting to provide an overview of the service and this will now become an area of focus in the next reporting period, subject to the impact of the COVID-19 situation.

The Panel continues to work closely with the CEO to ensure that there is synergy between what is happening in maternity and neonatal services and the wider corporate improvement plan. In recent weeks, in addition to the roll out of the new operating model, a new corporate performance management framework has been published and the organisation's wider engagement and communication strategy is nearing completion. All of these things will help to ensure that the improvements which are being delivered in maternity services are sustainable in the longer term.

There has been some progress against the complaints and concerns action plan with a revised structure, additional resources and a new complaints and concerns policy being put in place during the last quarter. There are signs of improved performance, particularly in terms of improvements in the timeliness for new complaints and a reduction in the number of complaints which are re-opened.

However, recent feedback from women and families suggests that resolving longstanding historical complaints remains a problem and the Panel will continue to focus its attention on this issue during the forthcoming period. There are also challenges around the quality of responses being provided and it is encouraging to see the Director of Midwifery taking personal ownership of that in so far as maternity services are concerned.

In the conclusion to its previous report, the Panel identified eight areas where it expected to see the Health Board make progress during the first quarter on 2020. These are set out in Section 7 of the report together with a brief assessment of what has been achieved.

SUMMARY OF CONCLUSIONS AND NEXT STEPS

Building on the solid foundations identified in its earlier reports, the Panel believes that the Health Board has made **further progress** during the first quarter of 2020. In particular:-

- there is evidence of further delivery against the Maternity Improvement Plan;
- there are clear signs that the service is improving;
- the initial phase of engagement has been completed with positive outcomes;
- the Clinical Review Programme has now commenced in earnest;
- the Health Board continues to engage constructively in the process;
- the improvement framework which has been put in place is working well;
- the IPAAF and the MIB have been further developed;
- an initial baseline assessment has now been conducted;
- there is evidence of 'Early Progress' against all three of the IPAAF domains.

On that basis, the Panel believes that the Health Board is **now firmly on track**, not only to deliver against the Royal Colleges' recommendations, but also, in due course, to deliver a maternity service of which they, their staff and their communities can be proud.

There is still much work to be done and a number of ‘next steps’ actions have been identified which will provide the focus for the next period and be monitored through the assurance process, which is now well established. These actions are summarised in section 9 of the report.

The Panel’s main concern at this time of great uncertainty is whether the Health Board will be able to maintain the longer-term focus and commitment that is now needed to build upon the solid platform which has been created.

RECOMMENDATIONS

In view of the progress which is being made and the ongoing commitment which the Health Board is showing to the improvement process, the Panel does not feel that it is necessary to make specific recommendations for the Health Board at this stage.

However, in view of the progress which is being made, the Panel is proposing that **the reporting cycle be extended to six months with the next report being due at the end of September 2020.**

The rationale for this recommendation is explained in further detail in Section 9 of the report.