INDEPENDENT MATERNITY SERVICES OVERSIGHT PANEL

Cwm Taf Morgannwg University Health Board

Progress Report
Executive Summary
September 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 required to report progress to the Minister on a six-monthly basis. This report, the fourth to be published to date, covers the period of April to September 2020.

By design, this report is more succinct than previous reports. It does not include detailed background information nor does it repeat, to any great extent, the analysis and conclusions contained within previous reports.

Previous reports together with other information, including the terms of reference for the Panel, can be accessed here on the Welsh Government website.

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 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

When the Panel last reported in April 2020, it concluded that the Health Board was firmly on track to deliver against the Royal Colleges' recommendations. The Panel also believed that the Health Board was making good progress towards its longer-term ambition to create an exemplar maternity and neonatal service of which they, their staff and their communities could be proud.

There was still much to be done to achieve that ambition and certainly no room for complacency. However, the Panel's main concern at that time was whether the Health Board could consolidate and build upon its early achievements against the background of the COVID-19 pandemic and the unprecedented operational and organisational challenges which were just beginning to materialise.

Six months on, whilst COVID-19 has undoubtedly had consequences, the Panel believes that the Health Board has done **remarkably well** in difficult and challenging circumstances to **maintain focus and momentum** and in doing so has made **further incremental progress** in delivering against its maternity improvement plans.

In reaching that conclusion, the Panel has taken into account a range of evidence and information which is set out in detail in the report which follows. In summary:-

- despite pressures elsewhere in the healthcare system, the Health Board and its senior leadership have remained fully committed to the Maternity Improvement Programme with no significant reduction in the level of engagement in the oversight process;
- the internal programme management arrangements which support the Maternity Improvement Programme have been fully sustained with no noticeable loss of focus or momentum and no reduction in resources or other capacity;
- support for the Panel's Clinical Review Programme has been sustained at pre-COVID-19 levels and additional staff (including some unable to work on the front line for health and safety reasons) have been brought in on an ad-hoc basis to increase the pace of progress.

That continued commitment and sustained momentum has enabled further incremental progress against the Maternity Improvement Programme, most notably:-

- a further 12 of the 79 actions within the Maternity Improvement Plan have been delivered, bringing the total now completed to 53[1];
- two of the three outstanding 'make safe' actions identified in the Royal Colleges' report (workforce planning and guidelines) have now been addressed, leaving only one (long term cultural change) still to be fully embedded;
- there has been further progression against the maturity matrices within the Integrated Performance Assessment and Assurance Framework (IPAAF) with all three domains now assessed as being in the 'RESULTS' phase.

[1] *In addition to the 12 actions delivered another 6 actions were removed from the Plan as part of a consolidation exercise. Further details are included in Section 3 of the report and Appendix A.*

At the same time, there have been other developments which have strengthened the capacity and capability of the Health Board to sustain those improvements in the longer term, most notably:-

- the Maternity Improvement Team has been integrated within the maternity service, enabling a transition to a continuous improvement approach which is 'owned' by frontline staff and embedded in day to day operations;
- neonatal service improvement has been incorporated within the Maternity Improvement Programme whilst joint oversight arrangements have been agreed and a baseline has been established for further improvement;
- the Maternity Improvement Programme has been extended to the Princess of Wales Hospital in Bridgend[2] so that maternity and neonatal services can be developed on a consistent basis across the Health Board area;
- the Maternity Improvement Plan has been remodelled into a more dynamic tool with clearer milestones and targets and a longer-term focus on continuous improvement beyond the Royal Colleges' recommendations;
- although COVID-19 has prevented the full rollout of the engagement and communications programme, the Health Board has developed new ways of communicating with women through increased use of social media and virtual engagement via the My Maternity My Way forum;
- solid progress has been made against the majority of the 14 actions identified as 'next steps' in the Panel's previous report.

Despite that further progress, it is important to emphasise that there is still a significant amount of work to be done to fully deliver against the Royal Colleges' recommendations and the pursuit of exemplar status remains a longer term ambition. In particular:-

- a number of the Royal Colleges' recommendations remain to be delivered and whilst they are work in progress, they mostly relate to areas such as culture change and leadership capacity which will take time to effect;
- there is still work to be done to fully implement plans to improve in areas such as managing concerns and complaints and the programme of work emerging from earlier engagement activities will need to be delivered;
- the integration of neonatal services within the Maternity Improvement Programme, whilst an essential step forward in terms of delivering a seamless service for women and families, has added additional work and increased complexity which needs to be carefully managed.

In addition, some activities (most notably the leadership development, culture change and communications training programmes) have been deferred as a direct result of the impact of COVID-19 and operational pressures have hindered progress in important areas such as managing sickness, the completion of consultant job plans and PADR compliance.

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[2] The Royal Colleges' review was conducted in the former Cwm Taf area and the special measures escalation arrangements apply only to the Prince Charles and Royal Glamorgan Hospitals. However, since that time, the Health Board has taken responsibility for maternity and neonatal services provided at the Princess of Wales Hospital. Whilst Princess of Wales is not in special measures, it is important that services are delivered on a consistent basis and the Health Board has agreed to work with the Panel to ensure that is achieved.

It is also important to emphasise that despite the innovative use of virtual technology, the opportunities to engage with women and families have inevitably been constrained and some elements of choice have had to be suspended. For example, the Health Board found it necessary to close the Tirion Birthing Unit at the Royal Glamorgan Hospital in order to safely manage the impact of COVID-19 related sickness absence.

All of these things will need to be reinstated and re-energised as soon as the current situation allows because they are critical to longer term sustainable improvement. The Health Board has plans to do that but it is important that any delay is minimised as far as possible. These issues and others are reflected in the 'next steps' actions which are identified throughout the report and summarised in Section 9 as the focus for the Health Board's attention during the next reporting period.

In concluding this Executive Summary, there are two important things which the Panel would wish to emphasise; one a caveat about the progress which has been made over the last six months, the other an emerging opportunity in the next phase of the Health Board's improvement journey.

The caveat is an important one. Over the past six months, the Health Board has undoubtedly made further progress against its maternity improvement plans and in particular in delivering against the Royal Colleges' recommendations. Through its internal assurance mechanisms, it has concluded 12 more of the Royal Colleges' recommendations have been delivered and embedded in operational practice.

As previously, the Panel has systematically assessed the evidence on which the Health Board has based its decision to 'sign off' those recommendations and in general terms has been reasonably assured that those decisions are appropriate. However, given the restrictions imposed by COVID-19, the validation process has not been as robust as it would have been in other circumstances. In particular:-

- the evidence review process has been confined to the assessment of paper evidence and probing conversations with senior managers and clinicians using remote technology;
- there has been no opportunity to test out the evidence through visits to operational units and structured conversations with staff in operational settings;
- some of the monitoring arrangements on which the Panel previously relied for validation (e.g. the PALS survey of women's experience) have been suspended;
- there has been limited opportunity to triangulate the Panel's assessments with evidence and information from other sources because the on-site inspection activities of external review bodies (e.g. Audit Wales and Healthcare Inspectorate Wales) and other organisations (e.g. Health Education and Improvement Wales and the Community Health Council) have been curtailed, re-programmed or conducted remotely.

The Panel does take comfort from the fact that the Health Board's internal monitoring and assurance arrangements have been incrementally strengthened over the past eighteen months and has no specific reason to doubt the robustness of its internal assessment. However, it does mean that the level of independent assurance which can be provided is more limited than on previous occasions.

On that basis, it will be necessary in the next reporting period for the Panel to revisit some of the recommendations which have been 'signed off' as delivered in the current period to ensure that they have been and remain embedded in operational practice. That process will be built into the Panel's forward plans.

The emerging opportunity relates to the next steps in the Clinical Review Programme. With the support of the Health Board and the Welsh Government, the pace and momentum of the Clinical Review Programme has been sustained throughout the current period, despite the restrictions on travel and social contact imposed by COVID-19.

As a result, the 2016-2018 lookback exercise is now well underway and during the next reporting period, the Panel will begin writing out to the women and families involved in the first cohort (the maternal morbidity and mortality category) to share individual review findings. It is also envisaged that the Panel will produce its first public facing report summarising the key themes emerging from this category towards the end of the year.

This will undoubtedly be a difficult and potentially distressing time for the women and families involved but also for Health Board staff members. The Health Board will need to ensure that all of the necessary resources and mechanisms are in place to provide the emotional, practical and administrative support which will be required to support the process before the information is shared with women and families or released into the public domain.

Not only will the Health Board need to explain what it has done since the Royal Colleges' review to make its services safer and more effective, it will also need to demonstrate that the culture of the organisation has changed too. In particular, it will need to demonstrate that the women and families who have been most affected by its previous failings are at the forefront of its thinking and display a genuine commitment to putting things right in an open, transparent, responsive and compassionate manner.

The senior leadership of the organisation has identified this as a significant opportunity to rebuild public trust and confidence and is developing its plans accordingly. However, the Panel would encourage the Board to reassure itself that those plans are suitably comprehensive and sufficiently robust to manage what will undoubtedly be an important, but potentially difficult, step forward in its improvement journey.

NEXT STEPS - Action 1: The Panel would encourage the Health Board to take steps to reassure itself that the plans it is currently developing to manage the clinical review feedback process are robust and comprehensive.