Bundle Health Board Meeting 30 April 2019

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

EXTRAORDINARY

HEALTH BOARD MEETING

Tuesday 30 April 2019
Ynysmeurig House, Abercynon

09:30am

AGENDA

		Lead / Attachment
PART 1. PRELIMINARY MATTERS		
1.1	Resolution to nominate Mr Paul Griffiths (Independent Member and Chair of the Audit Committee) to Chair the Board meeting	Chair / Oral
1.2	Welcome and introductions	Chair / Oral
1.3	Apologies for absence	Chair / Oral
1.4	Declaration of interests	Chair / Oral
Part 2. GOVERNANCE, PERFORMANCE AND ASSURANCE		
2.1	Maternity services	Chief Executive **Attachment**
Part 3. OTHER MATTERS		
3.1	Any other urgent business	Oral
3.2	Date of next public Board meeting **Thursday 30 May 2019, 2.00pm** **Ynysmeurig House, Navigation Park, Abercynon**	

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CYFARFOD EITHRIADOL O'R BWRDD IECHYD

Dydd Mawrth 30 Ebrill 2019
Ty Ynysmeurig, Abercynon

09:30y.b.

AGENDA

		Arweinydd / Atodiad
RHAN 1. MATERION RHAGARWEINIOL		
1.1	Penderfyniad i enwebu Mr Paul Griffiths (Aelod Annibynnol a Chadeirydd y Pwyllgor Archwilio) i gadeirio cyfarfod y Bwrdd	Cadeirydd / Ar Lafar
1.2	Croesawu a Chyflwyno	Cadeirydd / Ar Lafar
1.3	Ymddiheuriadau am Absenoldeb	Cadeirydd / Ar Lafar
1.4	Datganiad o Fuddiannau	Cadeirydd / Ar Lafar
RHAN 2. LLYWODRAETHU, PERFFORMIAD AC ANSAWDD		
2.1	Maternity services	Prif Weithredwr **Atodiad**
RHAN 3. MATERION ERAILL		
3.1	Unrhyw Fusnes Brys Arall	Ar Lafar
3.2	Dyddiad y Cyfarfod Nesaf **Dydd Iau 30 Mai 2019, 2.00 y.p.** **Tŷ Ynysmeurig, Parc Navigation, Abercynon**	

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 2.1** **30 April 2019**

University Health Board Report
MATERNITY SERVICES

Executive Lead: Angela Hopkins
Author: Angela Hopkins
Contact Details for further information: Chief Executive 01443 744800

Purpose of the Health Board Report
The purpose of this report is to provide the Board with an update on the recent review of Maternity Services (in the former Cwm Taf University Health Board area), outline the key actions already being taken and seek endorsement for further improvement actions to improve quality, safety and patient experience. The report aims to: • Provide a summary of the work that has been undertaken to date, in order to identify the extent and detail of the concerns • Outline a summary of progress in delivery of the action plan being overseen by the Maternity Improvement Board • Summarise the outcome of the review of serious incidents for the previously agreed reference period • Provide an update on the validation of maternity data for performance reporting and submission to national audits • Discuss and provide an initial response to the key findings of the recent review undertaken by the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM) recognising that the report has only just been published and will require further full and detailed consideration by the Board • Endorse the further actions required to respond to the recommendations of the RCOG & RCM.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within its approved 3 Year Integrated Medium Term Plan 2019-2022 and the related organisational objectives aligned with the 'Quadruple Aim' described within 'A Healthier Wales' (Welsh Government, June 2018) these objectives in summary are: • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future.

	• To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report focuses on all of the above objectives.
Supporting evidence	There is a comprehensive list of references and where required appendices, to assist the Board's review of the updates referenced within the report.

Engagement – Who has been involved in this work?
This Report has been developed from a range of work undertaken across the Health Board, which has involved internal and external staff as appropriate.

Health Board Resolution to:							
APPROVE		**ENDORSE**	√	**DISCUSS**	√	**NOTE**	√
Recommendation	The Health Board is asked to: • **DISCUSS** and **NOTE** the updates contained in the early part of this report • **CONSIDER** and **REVIEW** the failings that have occurred in the usual governance and communication processes surrounding the receipt and consideration of the draft report prepared by the secondee Consultant Midwife • Formally **RECEIVE** and **DISCUSS** the RCOG/RCM Review into Maternity Services in the former Cwm Taf University Health Board • **ACCEPT IN FULL** the findings and recommendations of the RCOG/RCM review; • **OFFER A FORMAL PUBLIC APOLOGY** to women and their families who have had a poor experience or outcome of maternity care in Cwm Taf. • **ENDORSE** the proposed next steps.						
Summarise the Impact of the Health Board Report							
Equality and diversity	There are no directly related Equality and Diversity implications as a result of this report.						
Legal implications	There is reference to legal processes e.g. Clinical Negligence and 'Putting Things Right' regulations.						
Population Health	The delivery of safe high quality maternity services across Cwm Taf Morgannwg UHB is essential to good public health.						
Quality, Safety & Patient Experience	There are significant quality, safety and risk implications referenced within the report and its related documents.						

Resources	There are no direct financial resource implications contained within the report although it is expected that investment will be required in supporting the delivery of the required improvement actions. This will need to be subject of further Board consideration and decision.
Risks and Assurance	There are significant risks and assurance issues outlined within the report and its supporting documents, that the Board will need to consider.
Health and Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The work reported in this summary and related annexes take into account many of the related quality themes.
Workforce	There are references to workforce and related factors contained within the report and its supporting documents.
Freedom of information status	Open

MATERNITY SERVICES UPDATE

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to provide the Board with an update on the recent review of Maternity Services (in the former Cwm Taf University Health Board area), outline the key actions already being taken and seek endorsement for further improvement actions to improve quality, safety and patient experience.

The report aims to:

- Provide a summary of the work that has been undertaken to date, in order to identify the extent and detail of the concerns
- Outline a summary of progress in delivery of the action plan being overseen by the Maternity Improvement Board
- Summarise the outcome of the review of serious incidents for the previously agreed reference period
- Provide an update on the validation of maternity data for performance reporting and submission to national audits;
- Discuss the key findings of the recent review undertaken by the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM) recognising that the report has only just been published and will require further full and detailed consideration by the Board
- Endorse the further actions required to respond to the recommendations of the RCOG & RCM.

This report provides the Board with the opportunity to discuss these important matters set against the context of the RCOG & RCM report commissioned by the Minister for Health and Social Services.

2. BACKGROUND / INTRODUCTION

2.1 Overview

Members of the Board will know that provision of Maternity Services has been a key feature of the Health Board's business, since the launch of the South Wales Programme engagement and consultation exercise. Members will also understand that the related decisions, made by this Board and other NHS Wales organisations' in 2016, where changes to the delivery of Paediatric, Obstetric & Neonatal Services were agreed on a Regional basis, would impact the greatest on the former Cwm Taf University Health Board. Whilst there is a significant amount of detail available, for ease of reference, a summary of the more recent chronology relating to Board Reporting, is provided at **Appendix 1**.

Members will also be aware that regular updates on Paediatric, Obstetric and Neonatal services have been provided to the Board since the approval of the South Wales Programme. This is important context in considering the very serious and significant concerns raised by the more recent internal reviews and the external review undertaken by the RCOG & RCM, following the Health Board identifying, raising and reporting to Welsh Government in Summer 2018, an under reporting of serious untoward incidents via Datix (the Health Board's incident reporting system) within its Maternity Service.

2.2 Raising concerns about incident reporting – recent background

Following changes in the senior management team and clinical governance arrangements in the Cwm Taf maternity services early in 2018, concern was expressed internally that there was potential variation in the reporting arrangements and investigation of incidents. This meant that the Board could not be wholly assured that all serious incidents had been appropriately investigated and any learning fully addressed.

This concern was initially escalated in the early summer 2018 to the responsible Executive Directors; discussed with Welsh Government in August 2018; presented to the August 2018 Health Board development session; and reported to the Health Board Quality, Safety and Risk Committee 'In Committee' in September 2018.

The concerns were reported in outline at the Public Board meeting in September 2018, with a more detailed report presented to the Public Board meeting in November 2018 https://cwmtaf.wales/we-are-cwm-tafmorgannwg/board-papers/?drawer=Board_Papers*2018-2019.

These concerns, were considered and discussed within the broader context of:

- South Wales Programme outcome and related concerns for staff and patients about the future location and delivery of services
- Staff movement and challenges associated with staffing levels given the planned change in service location
- The need for service redesign to address a very medicalised model of obstetric care which includes high intervention rates that are outside benchmarked norms
- Changes in Midwifery leadership.

The Board will also recall that repeated actions have been taken over the past 5 years to try to address some of the longer-standing leadership & staff engagement challenges in the maternity service. These actions have resulted in periodic improvements but sustaining staff engagement has been extremely challenging. This has clearly had a major impact on where the service is today.

The apparent low level of Datix reporting of Serious Untoward Incidents (SUIs) and an early assessment of recurring themes in incidents and complaints was reported to the Board and shared with Welsh Government in August 2018.

2.3 Board agreed review processes

In correspondence with Welsh Government in August 2018, the Executive Team outlined a proposed 4-Stage review process which was subsequently presented to the Board Development session on 30 August 2018 for approval.

The 4 stages outlined included:

Stage 1 Internal review of key performance information to scope the issues within the service.

Stage 2 Analysis and cross-referencing of all the information generated from Stage 1 to inform the development of an initial action plan (Maternity Improvement Plan). This phase included the commissioning of an internal review from the secondee Consultant Midwife to be undertaken during September 2018.

Stage 3 Following the completion of Stages 1 and 2, an external review to be undertaken in two sequential phases:

Phase 1 By external experts from within NHS Wales
Phase 2 A Royal College Review (RCOG)

Stage 4 Ongoing scrutiny of all actions arising from the various reviews

The Board had initially planned on the basis that Stages 1 and 2 would be concluded by the end of October 2018; that the external scrutiny process from within NHS Wales would take place in November/December 2018; and that this would be followed up with the RCOG Review approximately 3 months later.

In correspondence from the Chief Nursing Officer dated 21 September 2018, the view was expressed that the *"Health Board would benefit from early external, objective input to support the changes needed in the maternity service".* In response on 26 September 2018, the Chief Executive (CEO) advised that the Health Board believed the proposed NHS Wales external review continued to offer the potential for added value to the improvement agenda and advised that in recognition of the level of ongoing concern, a recommendation would be made to the Board on 27 September 2018, to bring forward the proposed RCOG review.

This was agreed by the Board on 27 September 2018, discussed with Welsh Government in a meeting on 28 September 2018 and communicated to staff and stakeholders on 3 October 2018.

On 5 October, in a written statement, the Minister for Health and Social Services, Vaughan Gething AM advised that Welsh Government would be directly commissioning the RCOG review.

Welsh Government aimed to mobilise the RCOG Review before the end of the calendar year and given the potential overlap in timing with the Health Board commissioned external review scheduled for November, the decision was taken to stand-down that particular review and pause other internal review processes (other than completion of the clinical case reviews) as the RCOG review process would take precedence.

The RCOG Review subsequently took place on 14-17 January 2019.

2.4 Enhanced oversight of maternity services and improvements

Whilst the various review processes were underway, the Board agreed that given the extent of the concerns within the maternity service there should be a period of enhanced oversight to better understand risk and maximise the opportunities to improve our Maternity Services in advance of the planned consolidation of services at Prince Charles Hospital.

It was also determined that all of the key activities arising from the various review processes would need to be contained within a single Maternity Improvement Plan. In response to that decision, actions from the Healthcare Inspectorate Wales (HIW) unannounced visit and the draft report written by the consultant midwife have also been included in the Maternity Improvement Plan.

The decision was therefore taken to establish a Maternity Improvement Board, to oversee the development and delivery of the improvement plan. An Independent Chair, external to the Board, was appointed with membership drawn from the service and Health Board management team. Membership also included the Vice Chair of the Board (as chair of the Quality Safety and Risk Committee - QSR) with Welsh Government and Healthcare Inspectorate Wales invited to be in attendance.

Assistance was secured from the Welsh Government Delivery Support Unit (DSU) to support the multidisciplinary team (MDT) in the process elements of reviewing the SUIs.

Weekly maternity oversight meetings, attended by Welsh Government officials, were established in addition to the scheduled monthly meetings of the Maternity Improvement Board. The Chief Executive and other senior officers also met periodically with senior officials in Welsh Government to discuss the ongoing reviews and related progress.

2.5 Reporting of various review processes and associated learning

In parallel with the preparation for the various reviews, there were a number of internal pieces of work that were being undertaken, which were individually and collectively contributing to both the understanding of the extent of the challenges within the service and the changes necessary to secure improvements.

These included:

- A detailed review of the 43 Serious Untoward Incidents (SUI), from the reference period January 2016 to September 2018 agreed by the Board , to ensure that all improvements action were being appropriately identified and addressed
  Monthly updates provided to the Board

- A comprehensive refresh of incident reporting processes in the maternity service
  Presentation to Board members on 27 September 2018

- A review of the Health Board performance against national audits
  Presentation to Board members 31 October 2018.

A further key piece of work that fed in to the development of the Maternity Improvement Plan, but which was not formally taken through the Health Board's normal governance process, was the internal report commissioned from the secondee Consultant Midwife in August 2018. This formed part of the Stage 2 review of key performance information to scope the problem and inform future stages of the review processes.

The draft report was submitted to the senior managers involved in commissioning the work on 1 October 2018. One individual was nominated to co-ordinate comments on the draft for both accuracy checking and clarification with the author. Comments were collated and summarised by 26 October 2018, in advance of a meeting with the author scheduled for 31 October 2018.

Unfortunately, on the day before the planned meeting, unforeseen circumstances, totally unrelated to the work being done, meant that the author was unable to attend. The secondment ended, at the request of the individual on 7 November 2018 and it was not possible to rearrange the planned meeting before the individual returned to her substantive role.

The Interim Director of Nursing, Midwifery and Patient Services wrote to the author on 22 November 2018, requesting further discussion and clarification of some aspects of the report. A response was received on 9 January 2019, stating that the author had nothing further to add. The report and appendices are attached as **Appendix 2** and have been redacted in places to preserve the anonymity of individuals.

These circumstances meant that there was confusion regarding the final status of the report and it was not formally received by the Maternity Improvement Board (MIB) as originally intended. This was a failure in the Health Board's usual governance and communication processes. As a minimum, the receipt of the draft report should have been reported to the MIB and when it became clear that it was not going to be possible to undertake the usual scrutiny and accuracy checking before finalising the report, this also should have been reported to the MIB and a formal decision taken regarding the handling of the draft report.

Had the reporting through the MIB taken place, as a minimum the existence of the report would have been reported to the Quality Safety and Risk (QSR) committee of the Board and through those minutes to the Board itself. Given the content of the report, had usual governance processes applied, it is likely that the report would have been considered by the QSR Committee on 6 December and consideration given at that meeting to the nature of reporting to the Board aligned with the progress updates on maternity services.

This report outlined a number of significant challenges relating to:
- Dysfunctional systems for reporting and investigation of incidents
- Culture
- Leadership within the service
- Silo-working with lack of role clarity and multidisciplinary working.

The report also raised questions about data quality and systems for reporting which were not able to be validated with the author but which are important issues going forward and are referred to later in this report (Section 3).

The failure to formally receive and discuss the draft report itself is fully accepted. However, the Board will wish to know that the findings and recommendations made were cross-referenced with the Maternity Services Improvement Plan and where they were not already part of the work-programme, the plan was updated accordingly.

2.6 Staff Engagement

Members will note that at the same time as the review processes have been ongoing, it was important to strengthen staff communication and engagement.

A system of regular staff face-to-face briefing sessions was put in place from 3 October 2018, led by the Interim Director of Nursing, Midwifery and Patient Services along with the issuing of regular Maternity Staff Bulletins. All staff working in maternity services were invited to attend daytime and evening communication sessions running at both the Royal Glamorgan Hospital and Prince Charles Hospital. The key purpose of these sessions was to listen to staff concerns and agree potential solutions.

As part of the communications plan, staff were provided with regular written updates, which included a section entitled 'You said, we did' to share joint solutions and progress with issues raised.

Members will wish to note that staff side colleagues were invited to attend, to provide support to staff. In addition, the Chair, the Vice Chair and a number of Executive Directors also attended. Furthermore, the Chief Executive, the Executive Medical Director and the Interim Director of Nursing, Midwifery and Patient Service held an evening session for consultant medical staff and their medical teams on 1 November 2018, to listen to concerns and to brief them on the process of reviews established at that time.

Board Members will realise that there have been a large number of informal visits by the Chief Executive, Independent Members and Executive Members of the Board to the maternity service over the past 6 months.

These visits have provided an opportunity for staff to speak directly with the Chief Executive and members of the Executive team, about outstanding concerns resulting in direct actions and in some instances, significant additional works being undertaken to enhance the new unit following requests and advice from maternity staff.

It is fully acknowledged that ongoing communication and engagement is critical to the success of changes necessary to improve maternity service.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

In response to all the concerns articulated above, four key pieces of work have been progressed over the last six months as follows:

- The development and ongoing delivery of the Maternity Improvement Plan overseen by the Maternity Improvement Board
- The completion of the internal review of the 43 serious untoward incident cases identified at the beginning of this process for the agreed reference period
- An initial internal review of maternity data sources and reporting
- The RCOG & RCM review.

For each of these key areas of work, an update is provided for the Board for discussion and consideration.

3.1 Progress update – Maternity Improvement Plan

A comprehensive Maternity Improvement Plan has been developed drawing on the work of the various internal review processes and feedback from staff engagement.

Recommendations from the internal draft Consultant Midwife report, the unannounced Healthcare Inspectorate Wales inspection of the maternity unit in Royal Glamorgan Hospital in October 2018 available here: http://hiw.org.uk/docs/hiw/inspectionreports/210119royalglamorganmaternityen.pdf and the immediate feedback from the RCOG & RCM team visit in January 2019, have all been included.

Progress continues to be made with delivery of the Maternity Services Improvement Plan. This is tracked through the weekly maternity assurance meetings and formally reviewed by the Maternity Improvement Board, which is scheduled to meet monthly. Progress will be reported to the Board's Quality, Safety & Risk Committee.

Of necessity, this is a dynamic plan with actions added in response to ongoing review and engagement. Clearly the Board will note that this plan will be further reviewed and updated in light of the publication of today's reports.

A number of milestones have already been achieved and these include;

- The immediate actions raised by the RCOG & RCM during their January 2019 visit to the UHB, which included;
    - Improvements required in Consultant Labour Ward cover. **Completed**. Labour Ward Consultant cover increased in line with RCOG requirements. In support of this, accommodation has been refurbished in PCH for Consultants to be resident on call out of hours, if they live outside the 30 minute RCOG call in time standard.
    - Support for trainee Doctors. **Progressed.** The increased availability of Consultants has facilitated the increased support and the Health Board must continue to work with trainees to ensure this progresses further.
    - Accessibility of protocols, guidelines, escalation processes and triggers. **Completed.** Clinical Guidelines updated, approved and available with a Screen shot to all staff on SharePoint (staff intranet site) on how to access guidelines. Revised Trigger List produced. **Completed.**
    - Strengthened induction pack for junior doctors. **Completed.** Mandatory Induction Programme now in place.
    - Improved Consultant attendance at high risk antenatal clinics. **Completed.** Interim Job Plans in place with dedicated consultant attached to clinic.
    - Review of escalation protocols for midwifery staffing levels. **Completed.** Daily Situation Report provided on activity and staffing levels. Escalation protocol revised following move to PCH.
    - Proceed swiftly with the planned change to admit babies into the neonatal unit at the Royal Glamorgan Hospital at 32 weeks gestation or above, from the level at the time of the review of 28 weeks gestation or above, to align with best practice across Wales.

Completed. Change enacted within 24 hours of feedback, with close liaison between obstetric and neonatal teams.

- The transfer of Obstetric and Neonatal Services from RGH to Prince Charles Hospital (PCH) was successfully achieved during the weekend of 9 and 10 March 2019.
- Successfully established the Freestanding Midwifery Unit at the Royal Glamorgan Hospital (RGH) for women with lower risk pregnancies. The service at RGH is complemented by Consultant-led ante-natal clinics, a Midwifery Day Assessment unit with community midwifery services across Cwm Taf supporting care in the home, including the option for women to choose a home birth.
- Progress with development of a Maternity Strategy & Vision, which included an engagement event with key Stakeholders, which was held on 12 April 2019.
- Medical appointments:
    - New Interim Clinical Director appointed 9 March
    - 3 further substantive Consultant appointments made at interviews held on 26 April. One will commence mid-June with the other two within 3 months
    - Middle-grade doctor appointment early June 2019
    - Fixed-term Middle-grade in place to cover maternity leave
    - Senior House Officer rota revised from April, to include 1:10 cover at night
    - Current over-establishment on medical rotas in place to cover release of trainee doctors for deanery training
    - An additional tier of doctors has been established for night cover, working alongside the Senior Clinical Midwives.
- Midwifery appointments:
    - Deputy Head of Midwifery commenced 1 April 2019
    - Substantive Consultant Midwife commenced 16 April 2019
    - Fetal Surveillance Midwife commenced in post on 9 March 2019
    - Intra-partum Lead Midwife post to be advertised
    - Integrated Governance Lead post to be advertised
    - Band 5 and 6 Midwifery Posts remain on a rolling advertisement.
- Improved staff training compliance.

Further ongoing significant challenges include:

- The criticality of our midwifery staffing levels.
    - In response the Board will note the establishment of a real time staff monitoring system, with daily SITREPs report to the lead Executive and Chief Executive. There is also a daily conference call hosted by the lead Executive to discuss staffing levels and acuity.
    - Ongoing recruitment and retention of Midwifery staff.
    - Workforce scorecard being developed for performance monitoring.
    - Action to reduce staff sickness rates in place.
    - Birthrate Plus re-evaluation requested, with results due in July 2019.

In addition work has commenced with colleagues in Cardiff and Vale UHB and Aneurin Bevan UHB, through the Heads of Midwifery, to consider strategic options for the management of capacity and staff over the next 12 – 18 months.

- The ongoing work with clinicians to deliver the necessary changes in practice that underpin improved efficiency and effectiveness of clinical care. These changes will improve quality and the experience of care and include:
    - Reductions in the medicalisation of maternity services for those women where it is safe and appropriate to do so
    - Reductions in the numbers of inductions and interventions in labour in line with best-practice standards
    - Reductions in caesarean section rates

- The perceived 'punitive' culture within the service
    - An organisational and development plan is being implemented for all staff working in Maternity Services. External expertise to deliver a bespoke development plan to support staff through this transition period focusing on team building and with the following components:
        - Multidisciplinary team working
        - Clinical leadership
        - Supporting the development of a no blame culture
        - Compassion for women and each other
        - Managing change and innovation
        - Creating a new future
        - Personal development
        - Service change and new model for services.
    - Ongoing staff engagement sessions led by the Executive team
    - Refreshed directorate governance structure and purpose redefined

The Board will note the significant work undertaken by all staff working in Maternity, who are working extremely hard to ensure that safe services are delivered.

3.2 Progress Update – Review of outcomes from Serious Untoward Incidents (SUIs) Review

A serious untoward incident (SUI) is defined as an incident that occurred during NHS funded healthcare (including in primary care and community), which resulted in unexpected or avoidable death or severe harm of one or more patients, staff or members of the public. The levels of harm are outlined by the National Patient Safety Agency (NPSA).

For any adverse outcome in pregnancy, labour or post-partum, it is important to undertake an investigation to try to establish the cause; to identify whether there were any factors in the care that contributed to the outcome; to establish whether any harm was caused; and to consider whether the incident meets the threshold to report as an SUI to Welsh Government.

The established process identifies that for any potential SUI, there should be an early multi-disciplinary team (MDT) review of the care and treatment provided at that time. This should be undertaken within 48 hours of the incident and followed-up by completion of a Root Cause Analysis investigation within 60 working days. Applying the 'Being Open' policy is central to this process which involves full disclosure of all information to the patient.

This process is a requirement in keeping with the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 and has been reinforced as part of the revised systems within the Health Board since the potential under-reporting was identified last summer.

Of the circa 10,500 births in the reference period for this review (1 January 2016 to 30 September 2018), it was identified that there were 43 potential Serious Untoward Incidents that should have had a full MDT review.

Of the 43 incidents, 34 were reported at the time of the incident and 9 were reported retrospectively. Where incidents had already been reported, concerns were expressed that the nature of the investigation may not have been of sufficient quality to provide assurance to the Health Board of learning and improvement. Therefore, the Health Board required each of the 43 cases to undergo an internal MDT review to better understand what happened; to identify any learning (including particular themes or trends); and ensure that redress was appropriately actioned.

Each review consisted of a detailed analysis of the care and treatment provided at that time, reviewing the maternity records, medical records and obtaining obstetric, midwifery, neonatal and anaesthetic opinions where required to inform the review. The process takes a considerable amount of time and regular progress updates have been provided to the Board.

The internal multidisciplinary review of the 43 cases has been concluded. In line with proposed additional scrutiny and oversight determined by Welsh Government, there will now be further independent review of the work done to review these cases and the validated position, once complete, this will be shared with the Board in public.

The purpose of the SUI review is not just to establish whether there were any factors that could have contributed to the adverse outcome but also to identify learning that will improve quality and patient experience.

The reviews to date have also identified a number of areas for learning and improved practice including:

- The need to revise and embed the guidelines and improve the pathway for Induction of Labour
- Strengthen the handover and safety briefing processes in line with RCOG situational awareness
- Revise and reinforce escalation processes
- Revise and reinforce sepsis assessment protocols
- Review and implement updated Gap and Grow Policy
- Improve documentation (including clear identification of appropriate risk factors)
- Revise 'fresh-eyes' documentation for CTG
- Increased Consultant presence on labour ward and bedside obstetric rounds in line with RCOG standards
- Increased compliance with Neonatal Resuscitation update training as required by Resuscitation Council
- Confirmation of roles and responsibilities within the MDT
- Ensure all high-risk women have Consultant review in ante-natal clinic
- Revision of CTG training package for all clinicians.

In their direct discussions with the Health Board, women and their families have told us how important it is that we don't just address their own personal concerns and issues but that we also learn from their experiences so that care is improved for others in the future. All of the areas for improvement are included in the Maternity Improvement Plan and have either been actioned already, are in the process of being actioned or form part of the forward work-programme.

Two additional areas have also been identified which will be added to the Improvement plan. These include:

- Review of telephone triage processes and documentation
- Embedding emergency drills training.

The further external review will be extremely important in drawing the final conclusions about failings in care. At a very high level the issues identified from the internal process related to failures to identify anomalies and act in a timely and appropriate way on changes during antenatal care or labour. The numbers themselves are individually small, which makes it difficult to draw any firm conclusions about common failures. However, delays in appropriate intervention, albeit different interventions, appears to be a recurring theme in a number of the cases reviewed.

These included delays in:

- Induction of labour
- Assessment or intervention in changing clinical circumstances
- Neonatal resuscitation

This assessment is consistent with some of the commentary from the internal and external review processes linked to:

- Lack of timely and appropriate escalation
- Shortfalls in bedside Obstetric review
- Lack of role clarity
- Inter-professional communication and team working

Losing a baby, under any circumstances, is a tragedy for the woman and her family. To lose a baby where there is any suggestion that failings in care may have contributed to the outcome adds significantly to that distress and deserves proper investigation and redress as appropriate.

The Putting Things Right (PTR) guidance was produced for the NHS in Wales to enable responsible bodies to effectively handle concerns according to the requirements set out in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the Regulations").

Where it is identified that there is possible or confirmed failings in care, the individual case has been referred for consideration of Redress in line with the PTR Regulations 2011.

From the internal review process, there are 21 of the 43 cases that are currently being progressed or considered through the Redress or Clinical Negligence route with a further 2 cases already settled under Redress.These are summarised in **Table 1** below.

Table 1: 'Putting things Right' status

Status	Number of Cases
Clinical negligence – case in progress	8*
Redress – case settled	2
Redress – case in progress	11
Redress – case under consideration	2
TOTAL	**23**

**Of the eight cases currently being managed through the clinical negligence route, six cases were offered Redress but the individuals decided to progress through the clinical negligence route instead.*

3.3 Initial internal review of maternity data sources and reporting

An important issue identified as part of the Stage 1 Review of all key performance information agreed by the Board was the need to seek assurance on the reliability of the data being submitted to National Audits.

This was reinforced within the draft report of the internal review conducted by the secondee Consultant Midwife; raised in discussions with Welsh Government officials, and further referenced as part of the RCOG & RCM review.

A presentation was given to Board members in October 2018, outlining the various data sources used to provide performance information. The core data set is drawn from the Maternity Information System (MITS) where information for each individual woman is entered directly by the attending midwife following birth. This means that reconciliation of any audit data back to the MITS system is likely to give the most accurate and reliable source of information and assurance.

Reconciliation of incident reporting through DATIX (Health Board incident reporting system) directly to the MITS system as a mechanism of ensuring that potential incidents cannot be under-reported in future was one of the key measures implemented as part of the revised incident reporting system for maternity services in September 2018.

The Executive Medical Director has led an initial internal piece of work, with the support of the Director of Public Health and the Assistant Director of Performance and Information, to review data completeness and accuracy and seek to particularly establish whether there is any missing data which may impact on the interpretation of the Health Board reported outcomes.

Any suspicion about data quality (completeness, accuracy, timeliness, consistency) undermines credibility of and confidence in interpretation of outcomes data. It was therefore important that this process was clinically led by the Medical Director.

The aim of the initial exercise was to review the current arrangements in order to provide assurance to the Health Board of the quality of our data submissions to National audits and benchmarking comparisons.

As part of this review, maternity data from several sources was reviewed and triangulated. Discussions also took place with key data experts within the organisation and within the wider NHS Wales data community.

The data sets reviewed included:

- Information submitted to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)
- A summary assessment of data validation review work undertaken internally by the Assistant Director for Performance & Information
- Triangulation of our data submission with NWIS (NHS Wales Information Services) data and ONS (Office of National Statistics) data; and
- CHKS (Caspe Healthcare Knowledge System) Obstetric Scorecard.

The initial review has confirmed a high level of consistency between the various data sets and the data quality feedback from the external agencies is positive.

The two key audits which give the most useful consistent comparative data on maternity outcomes are the MBRRACE-UK Audit and the National Maternity and Perinatal Audit (NMPA).

The CHKS (Comparative Health Knowledge System) also publishes an Obstetric Scorecard which facilitates national benchmarking of a number of key quality indicators with information drawn from the main Health Board and Trust data systems across the UK. To further strengthen data quality we have suggested implementing a direct data upload from MITS (Maternity Information System) into CHKS to minimise the number of intermediate steps and reduce any potential for errors in data translation. This proposal will be further discussed at the All Wales Benchmarking Group on 2 May 2019.

The most recent MBRRACE-UK report is based on 2016 data with the 2017 report due to be published in July 2019.

When the 2017 report is published, the Health Board will undertake a manual reconciliation of the MBRRACE data-set to MITS, to identify any potential for errors in reconciliation. This will be reported back to the Board when complete.

We remain fully committed to complete data integrity to assure our patients and service users, ourselves, and our external colleagues that we can be confident in the interpretation of our nationally reported benchmarked outcome data.

In response to the RCOG & RCM review, further discussions will need to take place with Welsh Government to determine what further data validation both internally and externally will be required.

This will also be of critical importance to the Board in seeking assurance about the quality outcomes of our maternity service going forward.

3.4 Health Board response to the RCOG & RCM Review

The RCOG & RCM Review Report, published on 30 April 2019, can be accessed by following the attached link
https://gov.wales/sites/default/files/publications/2019-04/review-of-maternity-services-at-cwm-taf-health-board_0.pdf

There are two separate but linked documents. One is a detailed account of the outcomes of the engagement process with women and their families, which informed the overall review and the other is the report from the RCOG review team on Maternity Services in the former Cwm Taf University Health Board.

Both reports outline very serious concerns about the maternity service. There is a lot of detail in the report and it would not do justice to the importance of all

the findings and recommendations to attempt to summarise for the Board to consider.

That said, the key themes are in many ways consistent with the concerns being driven through the Maternity Services Improvement Board relating to:

- Culture and behaviours
- Lack of staff engagement
- Staffing levels
- Lack of role clarity and inter-professional working
- Assurance regarding data quality and compliance with national standards
- Systems for reporting, investigating and learning from incidents.

The quality and safety of care for patients is the utmost priority for the Board and the organisation generally. In the context of maternity services there have been failings in this respect, which have been clearly articulated in the various reviews and summarised in this paper.

A strong quality and safety culture is characterised by:

- Quality and Safety being everybody's business and individuals feeling empowered to challenge when things don't seem to be right
- Strong awareness, high visibility and continuous review of risks
- A system where learning and continuous improvement are constant
- Leadership, team-working and behaviours that put the patient at the centre of decision-making and
- No blame.

The various reviews identify that there is still considerable work to be done to ensure that these characteristics are firmly embedded in the maternity services and the Board will also need to consider assurance mechanisms across the wider organisation.

Whilst a 'no-blame culture' is really important in supporting open reporting, sharing and learning from errors and incidents, it does not over-ride individual and collective accountability for actions.

If there are circumstances where there is evidence of actions or behaviours that breach policies and codes of professional conduct, these are always dealt with very seriously with reference to regulatory bodies as appropriate.

The Board is fully committed to working with maternity staff to address concerns raised in the RCOG & RCM review about a perceived punitive culture and to create a more positive environment for shared learning and improvement, however, this does not cut across the need to follow due process in respect of professional standards should that become necessary.

The report particularly challenges the Board to consider its own systems of governance and assurance in light of the concerns raised. This includes systems

for scrutiny of data, regular review of key organisational risks and effective challenge to the Executive Team.

Board members will recall that following the visit by the Review Team in January 2019, direct feedback was given on a range of concerns that required immediate consideration and action. The details of those areas of immediate concern are outlined on Page 5 of the RCOG Report. They were reported to the Board at the time, included within the Maternity Improvement Plan and actioned accordingly.

The Board is also reminded that the review was undertaken prior to the planned move of services in March 2019. A number of the recommendations in the RCOG report make reference to the need for further assurance on the arrangements that need to be in place to support the service changes.

Following the review (but prior to receipt of this report) a detailed readiness assessment was undertaken taking into account issues already known to the service and additional issues raised through the review process. The relevant actions were completed prior to or as part of the service move and now that we have the final report these will be cross-referenced with the recommendations from the review to ensure everything that needed to be in place has been done.

The Board must fully consider the detail of the report and the Minister's response to ensure that the requirements on all areas for improvement are taken forward and implemented.

4. RECOMMENDATION

Work is already underway to make improvements in maternity care through the actions taken and being overseen by the Maternity Improvement Board. However, significant work remains to be done and success is dependent upon full engagement of women, their families and staff in delivering the necessary changes that will ensure that Cwm Taf Morgannwg has a maternity service that delivers best care for the population going forward.

The Board will need to draw on the skills and experience within the existing service as well as external expertise to help drive change and improvement in line with best practice and the needs of women.

It will be essential for the Board to work closely with Welsh Government officials and others to strengthen systems of governance and scrutiny of the improvements to be made in response to this review. Alignment of internal governance systems with whatever additional oversight arrangements are determined by Welsh Government will be essential to deliver a comprehensive, transparent and accountable response to the very serious issues identified.

The Board is advised to accept in full the Report's findings and commit to delivering all the recommendations made.

The Health Board is asked to:

- **DISCUSS** and **NOTE** the updates contained in the early part of this report;
- **CONSIDER** and **REVIEW** the failings that have occurred in the usual governance and communication processes surrounding the receipt and consideration of the draft report prepared by the secondee Consultant Midwife;
- Formally **RECEIVE** and **DISCUSS** the RCOG Review into Maternity Services in the former Cwm Taf University Health Board;
- **ACCEPT IN FULL** the findings and recommendations of the RCOG review;
- **OFFER A FORMAL PUBLIC APOLOGY** to women and their families who have had a poor experience or outcome of maternity care in Cwm Taf.

A number of key actions must now be taken and brought back to the Board for decision at the next public meeting in May. These next steps will need to include:

- Full reconciliation of all recommendations from the RCOG report to the existing Maternity Improvement Plan with the aim of identifying those areas where action has already been taken; action is in the process of being taken or where actions are included within the forward work programme. Any recommendations not already included will be added in to the Improvement Plan for endorsement by the Board.

- Review of the future role, function, membership and reporting arrangements for the Maternity Improvement Board to provide effective scrutiny and oversight of the delivery of the composite improvement plan. This will need to link closely with any further assurance arrangements the Board may wish to consider and any oversight mechanisms that might be put in place by Welsh Governance to provide independent scrutiny of progress.

- Specific engagement with external experts to support strengthening the Maternity Liaison Committee and associated systems for effective involvement and engagement of women and their families.

- Identification of opportunities for further learning from other maternity services across the UK to include the potential identification of a strategic partner to support learning and change.

- Urgent discussions with Welsh Government officials regarding:
    - Alignment of internal governance arrangements with any additional external oversight as determined by the Minister
    - The most appropriate mechanism for validation of performance data

- Any further review processes to be considered in response to the RCOG review.
- An update on correspondence received from external stakeholders and the Board's response, including where Chair's Action has needed to be taken.

Freedom of information status	Open

Appendix 1

Chronology of Maternity Services reports received at Board meetings since January 2018
https://cwmtaf.wales/we-are-cwm-tafmorgannwg/board-papers/

Date	Meeting	Discussion	Report/Minute Ref
28 March 2019	Public Board	Update on Maternity Services and Paeds, Obs, Neonates also included in the Chief Executives update report. Report received on Maternity Services.	**Reference** Chief Executive Update 28 March 2019 **Reference** Maternity Services report 28 March 2019
30 January 2019	Public Board Meeting	Update provided in Chief Executive's report on Paediatrics, Obstetrics and Neonates Report on Maternity Services received and discussed.	**Reference** Chief Executive Update **Reference** Maternity Services Report **Reference** Minutes 30 January
20 December 2018	Integrated Governance Committee (On Board Development Day)	Report from the Chair of the Health Board. Update received on discussions held with Cabinet Secretary particularly in relation to Maternity Services Report from the Chair of the Quality, Safety & Risk Committee – reference made to Maternity Services.	**Reference** 'Draft' Unconfirmed Minutes 20 December 2018 (in draft not yet public)

Date	Meeting	Discussion	Report/Minute Ref
29 November 2018	Public Board Meeting	Chief Executive provided an update on Paeds, Obs, and Neonates as part of Chief Executive update report. Maternity Services update report presented to Board Members	**Reference** Chief Executive Update Report **Reference** Maternity Services Report **Reference** Minutes 29 November 2018
27 September 2018	Public Board Meeting	Chief Executive provided an update on the Maternity Services Review and Paeds, Obs, Neonates in her Chief Executive update report	**Reference** Chief Executive Update **Reference** Minutes 27 September 2018
30 August 2018	Integrated Governance Committee (On Board Development Day)	Brief discussion held on maternity services review as part of the update provided on the Integrated Governance & Accountability Action Plan Brief update provided on maternity services as part of the Report from the Chair of the Quality, Safety & Risk Committee	**Reference** Integrated Governance & Accountability Action Plan **Reference** Report from the Chair of the Quality, Safety & Risk Committee **Reference** Minutes 30 August 2018

Date	Meeting	Discussion	Report/Minute Ref
26 July 2018	Public Board Meeting	Chief Executive provided an update on Paeds, Obs, Neonates in her Chief Executive update report	**Reference** Chief Executive Update report **Reference** Minutes 26 July 2018
31 May 2018	Public Board Meeting	Chief Executive provided an update on Paeds, Obs, Neonates in her Chief Executive update report	**Reference** Chief Executive Update report **Reference** Minutes 31 May 2018
29 March 2018	Public Board Meeting	Chief Executive provided an update on Paeds, Obs, Neonates in her Chief Executive update report	**Reference** Chief Executive Update report **Reference** Minutes 29 March 2018
31 January 2018	Public Board Meeting	Chief Executive provided an update on Paeds, Obs, Neonates in her Chief Executive update report	**Reference** Chief Executive Update report **Reference** Minutes 31 January 2018

Internal Review of Obstetric & Midwifery Services
Cwm Taf University Health Board

September 2018

Author [redacted] Consultant Midwife

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1 Glossary

AMU – Alongside Midwifery Led Unit

Badgernet – Neonatal patient data management system (used within all SCBU's and neonatal units across Wales)

BR+ - Birthrate plus

CBM – Clinical Board Meetings

CD – Clinical Director

CEO – Chief Executive Officer

CHC – Community Health Commission

COO – Chief Operating Officer

CPD – Continual Professional Development

CSfM – Clinical Supervisors for Midwives

CSR – Caesarean section rates

CTG – Cardiotocography

CT UHB - Cwm Taf University Health Board

Datix – Patient safety software (web based incident reporting)

DON – Director of Nursing

ELCS – Elective caesarean section

EMCS – Emergency caesarean section

Euroking – National maternity IT system (that updates consistently and in line with government led emerging initiatives as well as clinical enhancements)

GAP – Growth Assessment Protocol

GROW – Gestation Related Optimal Weight

HB – Health Board

HR – Human Resources

HIE – Hypoxic Ischaemic Encephalopathy

HoM – Head of Midwifery

HOMAG – The All Wales Heads of Midwifery Advisory Group

HTA –Human Tissue Authority

IOL – Induction of Labour

IUD – Intrauterine Death

KPI – Key Performance Indicators

LSA MO – Local Supervising Authority Midwifery Officer

LSCS – Lower Segment Caesarean Section

MBRRACE – Mothers & Babies: Reducing Risk through Audits & Confidential Enquiries

MDT – Multidisciplinary Team

MITs – Maternity Information Technology System (bespoke to Cwm Taf & built in house)

MLC – Midwifery Led Care

MLU – Midwifery Led Unit

MPB – Maternity Performance Board

NEWTT – Neonatal Early Warning Trigger & Track

NNAP – National Neonatal Audit Programme

O&G – Obstetrics & Gynaecology

OD – Organisational Development

PADR – Personal Appraisal & Development Review

PCH - Prince Charles Hospital

PDM – Practice Development Midwife

POW – Princess of Wales

QlikSense – Business intelligence and visual analytic software. MITs feeds directly into Qlik Sense

Q&S – Quality & Safety

RCA – Routine Cause Analysis

RCM – Royal College of Midwifery

RGH - Royal Glamorgan Hospital

SB – Stillbirth

SBAR – Acronym for Situation, Background, Assessment & Recommendation, to support appropriate communication

SCBU – Special Care Baby Unit

SFH – Symphysis Fundal Height

SGA – Small for Gestational Age

SI – Serious Incident

SOM – Supervisor of Midwives

SUI – Serious Unreported Incident

SWP - South Wales Plan

Trac – A large UK database of 'jobs boards' for health and public sector

UHB _ University Health Board

USS – Ultrasound Scan

WG – Welsh Government

WTE – Whole Time Equivalent

2 Introduction

This review has been undertaken in response to concerns relating to the quality and safety (Q&S) of maternity services provided by Cwm Taf University Health Board (CT UHB). The concerns were first raised by the newly appointed Head of Midwifery (HoM) in April 2018 and escalated to the executive team. Due to the nature of the concerns, it was agreed by the CEO, COO, Medical Director and Director of Nursing (DON) that a robust internal review should be undertaken.

The aims of this report are to describe:

1. The scale of the problem
2. Whether the problem is related to:
    a. Individual or more systemic failings
    b. Inadequate systems for reporting SUIs or failure on the part of individuals to follow an appropriate process
    c. Inadequate systems for investigating incidents or failure on the part of individuals to follow an appropriate process
3. Immediate actions which need to be put in place to provide assurance on quality of care and future reporting / investigations of incidents
4. The external assistance needed to validate and supplement the findings so that assurance can be given about the quality of future care

A draft report was initiated in April 2018 by the corporate patient safety team in response to the concerns that had already been escalated. After discussion with WG & the CEO it was decided that a 'fresh eyes' approach to the report was required. From the 21st August 2018, this was tasked to the newly appointed Consultant Midwife to be completed within a four-week period.

During this timeframe, a scoping exercise was undertaken to capture the background context and all areas of concern were comprehensively explored and analysed where data/time permitted. To support the robustness of this review, regional and national statistics have been used as a comparative where possible. This internal review addresses the concerns relating to maternity care provision in Cwm Taf during the period of 2015-2018, although, in some instances, important issues that pre-date 2015 have also been included.

Due to the tight timeframe of the review, some areas of discussion within the report will require a deeper analysis through external review to ascertain the true scale of the concerns. Where a conclusion cannot be reached regarding why failings initially occurred this is described as so through the report.

The following themes reoccurred through the investigation:

- Dysfunctional Systems
- Staff concerns about a punitive culture
- Lack of recognition & poor leadership
- A lack of interdisciplinary working

It should be noted however, that all themes were heavily intertwined with each other and therefore there is some overlap through the discussion. For instance, the concerns around a punitive culture, appears to be one of the factors for underreporting of incidents and is also reflective of poor MDT working.

3 Limitations of the Review

The main limitation of this internal review has been the short time scale to support an in-depth exploration and analysis. During the period of the review, an overview of the findings and failures identified have been explored and where data permitted a comparison with regional/national data has been considered. To drill down further, an external review of the systemic failings is recommended. This review is written in good faith with the information that has been presented and located.

4 Investigatory Findings

It is apparent that Cwm Taf maternity service has experienced a number of challenges over the years, particularly with the impact of the South Wales Plan (SWP), the fragility of the workforce and concerns around a punitive culture. To help set context to the findings, key junctures in the history of the service are reflected within this review.

5 Dysfunctional Systems

5.1 Clinical Governance:

The governance process prior to March 2018 was predominantly led by a two-person team, consisting of the HoM and Senior Risk Midwife. On exploring the governance processes, it was evident that the systems supposedly in place were led in isolation and in collaboration with several other working streams. The previous clinical Risk Manager was responsible for a number of working streams including clinical risk, clinical governance, GAP/GROW clinical lead, patient experience including complaints, prompt training and lead populator for the maternity dashboards. As a result of this high workload, there have been failings embedding systematic processes.

The previous system for reviewing clinical incidents within maternity was a weekly datix meeting undertaken by the HoM & Senior Risk Midwife. This included an initial review of the datix report, next steps/action plans and any closure of datix's. This process is believed to be separate from any corporate Q&S involvement, and appears not to have been investigated at Corporate/Board level. To ascertain the procedure for datix reporting, a pathway was located within the Risk Manager's file share, which was found to have been devised in April 2017 (see appendix 1). However, through an opportunistic finding, another datix flow chart was also identified dated January 2017 which was apparently 'ratified' for clinical use. It is unclear that either pathway was ever embedded operationally, as the process prior to the new HoM commencing appointment was a unidisciplinary approach with isolated weekly meetings to review all datix reports. The pathway located from January 2017 reflected a MDT approach

and for band 7/8a involvement, although it was apparent when the new HoM commenced appointment that a lead senior 8a midwife did not have datix access, which differs to what was set out within the flowchart. The pathway from April 2017 appeared to be heavily reliant on 'capability and disciplinary action' regardless of the nature of the incident and also suggested clinical supervisors for midwives (CSfM's) to undertake investigations. This was outside the scope of the new CSfM model, which was to move away from CSfM's having 'two-hats'. If annual leave or sickness occurred it is not clear whether the datix meetings went ahead and assessments of moderate and severe datix's appear to have also followed the same unidisciplinary approach with isolated investigations. Furthermore, obstetric and multi-disciplinary involvement appears to have been sporadic.

The roles and responsibilities of the wider multi-disciplinary team (MDT) that fed into the previous governance structure is difficult to quantify, as no terms of reference or defined quorum to any meetings such as governance, clinical risk, perinatal mortality and Q&S have been located. It was also reported by staff that prior to the new devised governance structure (April 2018), quarterly Q&S forums were the only active meetings, although, these were reported to be infrequent, poorly attended and having limited engagement. Reports and ad hoc action plans suggest that other meetings were also in situ such as clinical risk and governance, although minimal evidence was identified to support this and no standardisation of such meetings has been identified.

A vast amount of information associated with risk management, governance and Q&S was noted in the Risk Managers file share, although files were frequently incomplete with no logical order and no clear central database or sequential pattern of actions located. A lack of evidence to support working streams such as minutes, agendas and completed action plans was also noted and indicates that there was a lack of leadership or uniformity behind meetings. The same reoccurring themes have been raised through annual reports, as well as through clinical incidents and newsletters demonstrating that systems and procedures that were supposedly in situ to ensure proposed actions were safely implemented operationally were ineffective. The irregularity of meetings and ad hoc minutes/agendas, highlights a lack of structure and leadership at all levels. Sparse engagement and continuity from obstetricians has also been noted, with a heavy reliance on the Clinical Director (CD) to attend all meetings. Obstetric engagement across each hospital site has differed slightly, although again it has remained predominantly left to the CD to attend the majority of working streams.

Changes in senior leadership roles over the last 3 years have occurred periodically across each site and particularly around the time of the cultural findings that emanated from the pulse survey in January 2017 as well as through 'acting up senior positions' (December 2017 - March 2018). Despite changes in strategic leadership roles, it remains unclear as to why changes in governance processes were never explored and initiated then. Governance processes and access to datix reporting do not appear to have been challenged by any senior position or noted to be of significant concern, until the new HoM was in post.

December 2017 - January 2018 - On occasions, CSfM's were involved in reviewing cases particularly from a supervisory investigatory role. One email trail acknowledged concerns were raised to the HoM, Risk Manager & DON by the CSfM's around what was felt to be a case that had previously been miscategorised as 'no harm' and where

practice issues were noted to be of concern. However, despite the raised concerns, assurance of no harm was passed on to the DON. This was subsequently identified as requiring a root cause analysis (RCA) and Coroner's investigation, demonstrating the failure to recognise the severity of a clinical incident.

April/May 2018 - Following concerns relating to a number of unreported incidents including serious incidents (SI's) and a lack of robust investigations, it was agreed that a series of deep dives into maternal and neonatal events would be undertaken. This was to help provide assurance that incidents were appropriately investigated under the previous governance processes.

5.1.1 Deep Dive 1:

May 2018 - Prior to Deep Dive 1, it was acknowledged that several RCA's linked to datix reports in collaboration with action plans addressing learning needs remained incomplete and feedback mechanisms poor.

Through Deep Dive 1 a total of 68 maternal and neonatal events were reviewed; 34 of each were selected via the datix reports for the period of March to September 2017. The SBAR in appendix 2 outlines the overall findings of the deep dive and suggested recommendations to be implemented.

The main findings that emanated out of deep dive 1 acknowledged:

- 6/34 cases failed to recognise deterioration in fetal wellbeing and miscategorisation of CTG's was identified. The failure to recognise deterioration, resulted in two neonates requiring therapeutic cooling due to poor condition at birth
- Poor neonatal resuscitation was highlighted in 7/34 cases, this included failure to act, failure to follow guidance and a lack of timely escalation
- A lack of timely escalation to an appropriate professional was acknowledged in 9 out of the 34 cases
- Inappropriate use of fetal scalp electrodes in 4 out of 34 cases were identified as the first line of action to improve CTG's, which was noted to be outside practice and guidance
- 3 unreported SI's were identified and 2 cases were found to require MDT table top reviews. Evidence of the 3 unreported SI's were found to be previously datixed, although, 1 was closed without a review and 2 were closed with inappropriate review & no follow up. It was also apparent that the sharing of lessons learnt had failed to be appropriately disseminated.

5.1.2 Deep Dive 2:

August 2018 - Deep Dive 2 was initiated by the Senior Management Team to undertake a review of the stillbirths and neonatal deaths that occurred between 2016 – 2017 (see Table 1 regarding the overall outcomes). All 18 cases that were reviewed highlighted learning outcomes and reflected the same themes as of Deep Dive 1 and 3. From Deep Dive 2, a further 2 unreported SI's were identified and found to be

inappropriately managed. This included the inappropriate closure of datix's in isolation and without corporate scrutiny.

Table 1:

Outcome of Deep Dive 2:	
Number of cases met criteria for inclusion	**24**
Number of records available for review	**18**
Number of records **NOT** available at time of review	**6**
Number of records reviewed in Deep Dive 2 – fresh eyes	**18**
Number of cases identified as requiring a further multi-disciplinary review	**2**
Of the 2 cases which underwent MDT review following Deep Dive 2, Number of cases requiring a Serious Incident report	**2**

Noting the concerns in relation to the lack of robust data collection, historic underreporting and mismanagement of SI's that was identified, the new HoM requested a review regarding the completeness of the MBRRACE/Each Baby Counts report for all stillbirths, neonatal deaths and late fetal losses for the period of 2017. This was after recognition that the 2016 dataset that was sent to MBRRACE relating to Each Baby Counts was inaccurate along with incomplete data fields relating to characteristics to support the MBRRACE (2018) Perinatal Mortality Surveillance Report. A recent SBAR and review of all 2017 cases was devised by a senior midwife to ascertain compliance and help provide assurance; see appendix 3 for overall findings.

It was documented within the recent SBAR that the limitation of the review was the persistent lack of evidence to support what was documented within the Each Baby Counts reports. It was stipulated that 14 out of the 34 cases required multi-disciplinary reviews and that these had been undertaken around the time of the incident. However, no evidence to support this happened was identified. Of the 34 cases that required reporting to MBRRACE for the period of 2017, 26 were notified by the previous risk manager, 5 required amendment to support accuracy and 8 cases were unreported. These included 5 late fetal losses and 3 stillbirths.

5.1.3 Deep Dive 3:

17th September 2018 – Deep Dive 3 consisted of 15 cases, 13 of which were identified through Deep Dives 1 & 2 which required further review and 2 new cases. Following on from a multi-disciplinary review of the 15 cases, 5 required an RCA due to practice concerns and an additional 2 unreported SI's were identified. **This brought the total to 7 unreported SI's across all three Deep Dives**. These missed opportunities highlight the ineffective governance that was in place to appropriately investigate. One example of a missed opportunity was an SI from 2017 which was only discovered after a formal complaint was logged in August 2018. A further area of concern, is that the first letter received by the corporate team was considered to be insignificant and closed without further exploration due to it being outside the 12-month period of 'Putting Things Right'. As a result, a further letter of concern was filed by the family and is now being investigated as a formal complaint. This case was subsequently

brought through to Deep Dive 3 and has since been noted to be one of the unreported SI's.

Another case that came to light under similar circumstances was an unreported SI from 2017 relating to a 26/40 stillbirth at home. This was also only identified after a negligence claim was filed, subsequently the SI was reported late in 2018. The cases highlighted above are not unique and a number of other SI's have been identified through opportunistic phone calls as well as through complaints being logged. Concerns around complaint handling have also been identified whereby redress was supposedly paid without a robust investigation. This area requires further scrutiny.

From the 15 cases that were brought to Deep Dive 3, 6 were downgraded from SI's after a MDT discussion, which demonstrates the fundamental importance of clear governance structures with an MDT quorate to support decision making.
The overall learning outcomes from the deep dives and RCA's reflect the same reoccurring practice issues, as outlined below:

- Failure to acknowledge deterioration in fetal and maternal wellbeing through the miscategorisation of CTG's
- Safety briefings not always utilised and no standard process for safety briefings
- Lack of awareness from obstetrics and senior midwifery positions regarding the whole clinical picture, resulting in unsafe delays in care.
- On occasions and noted within two RCA's (2017 & 2018), obstetric review being undertaken in isolation and not bedside reviews (via telephone, case notes or Trium)
- Poor documentation and overuse of template stickers
- Delay in care with no clear explanation (often based on organisational issues irrespective of the clinical picture)
- Working outside scope of practice and failure to escalate

The same reoccurring areas of concern are reflective of the systemic failings at all levels to appropriately monitor service provision. This is evident through the ingrained culture of poor learning from incidents, lack of robust governance structures, lack of leadership/ownership and profound evidence of the 'silo effect'. An example which demonstrates the ingrained culture of a lack of learning from incidents is noted below. Two RCA's relating to a term stillbirth (2016) and a neonatal death (2017) both demonstrated unnecessary delays in care and failure to recognise deterioration in wellbeing. The practice issues documented within both reports are almost identical to each other regarding the contributory factors, recommendations and lessons learnt. Had an effective multi-disciplinary investigation taken place at the time of the first incident and robust systems implemented to monitor themes and trends, then it is likely that such concerns would have been identified much earlier on and could have been appropriately addressed.

5.1.4 Lessons learnt:

As a means to disseminate lessons learnt it was noted that newsletters such as, 'things to remember', 'risky business' and 'maternity risk news' were sporadically shared throughout 2017 by the Risk Manager, although, it is unclear as to whether all three documents were a mirror image of the former one due to the similarities. It was also

unclear regarding how this information was distributed to staff as there appears to be no sequential pattern or uniformity to the frequency of the newsletters and the overall aim. The newsletters that were located, highlighted the same themes around ineffective GAP/SFH measurements, neonatal hypoglycaemia and missed opportunities around recognising deterioration in fetal wellbeing. The resources used to support learning outcomes is not apparent and suggests that the reoccurring themes were not recognised at a senior level to be of concern. Scant mention regarding weekly CTG review meetings for staff to access was noted, although, no ownership from obstetrics was identified and subsequently left to the practice development midwife (PDM) to coordinate and facilitate. As a result, numerous CTG review meetings have been cancelled due to lack of engagement. The lack of ownership and engagement from obstetrics remains the same currently, as a result CTG weekly reviews have not been facilitated (August-September 2018).

Sharing of lessons learnt was repeatedly sited within Cwm Taf's action plan in response to the Morecombe Bay enquiry (see appendix 4). It was also noted that training, governance and MDT working were all reported to be embedded into practice and that the *'Directorate considers good systems are in place to provide assurance'* and *'good processes in situ to inform staff'*. A number of the actions were flagged as green (low-risk) and classified as 'completed' within the action log. Although, the practice issues that have been highlighted so far and the missed opportunities, reflect a very different picture.

5.2 Stillbirths (SB's):

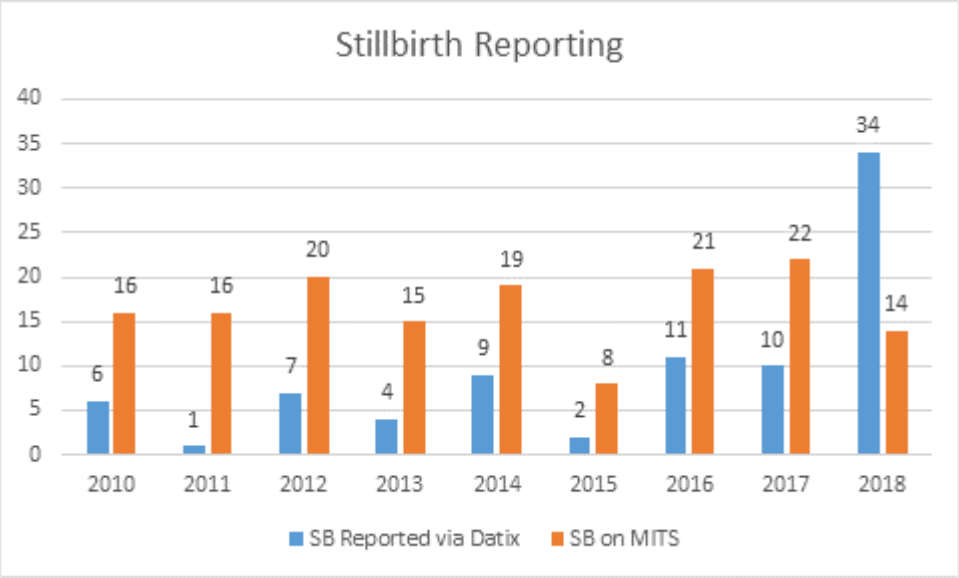
September 2018 – Taking into account the increased number of unreported incidents identified across the maternity service, a trawl of the total number of datix reports relating to SB's across both sites were explored. See figure 1 outlining the actual cases of SB's vs the datixed cases. Between 2010 to date, a total of 84 SB cases were reported via datix, however, when comparing these low numbers against MITS and Qliksense, 151 SB's were in fact registered. **Therefore, 67 stillbirths since 2010 have not been reported or investigated.** Yet the HB's response to the CHC in February 2018 stipulated that '*all SB's were datixed and learning outcomes embedded into clinical practice'*. This reflects the inaccuracy of the report and failure to recognise the ineffective systems.

The rise in datix reporting noted in 2018 as per figure 1, is predominantly reflective of the ongoing work to retrospectively investigate the unreported cases. As a result, the numbers prior to this work would have been considerably lower. It therefore, raises a question as to why such low numbers were not acknowledged as a red flag trigger at Corporate and Board level as well as at Directorate level. The retrospective work that is currently ongoing is concentrated on the period of 2016-2018 and as a result the unreported cases of SB's prior to 2016 are yet to be explored. It is believed that the datix reporting system came into full implementation around 2011, although, this is unclear as datix reports relating to SB's have been identified as far back as 2009, which would indicate earlier implementation of the system.

Despite a considerable amount of work being commenced around ensuring better systems are in place, a number of cases recently (July – September 2018) have been

noted to be missed opportunities in care and as a result avoidable adverse outcomes repeatedly being missed.

Figure 1: SB incidents vs Reported Incidents *(between 50-75% each year not reported)* *



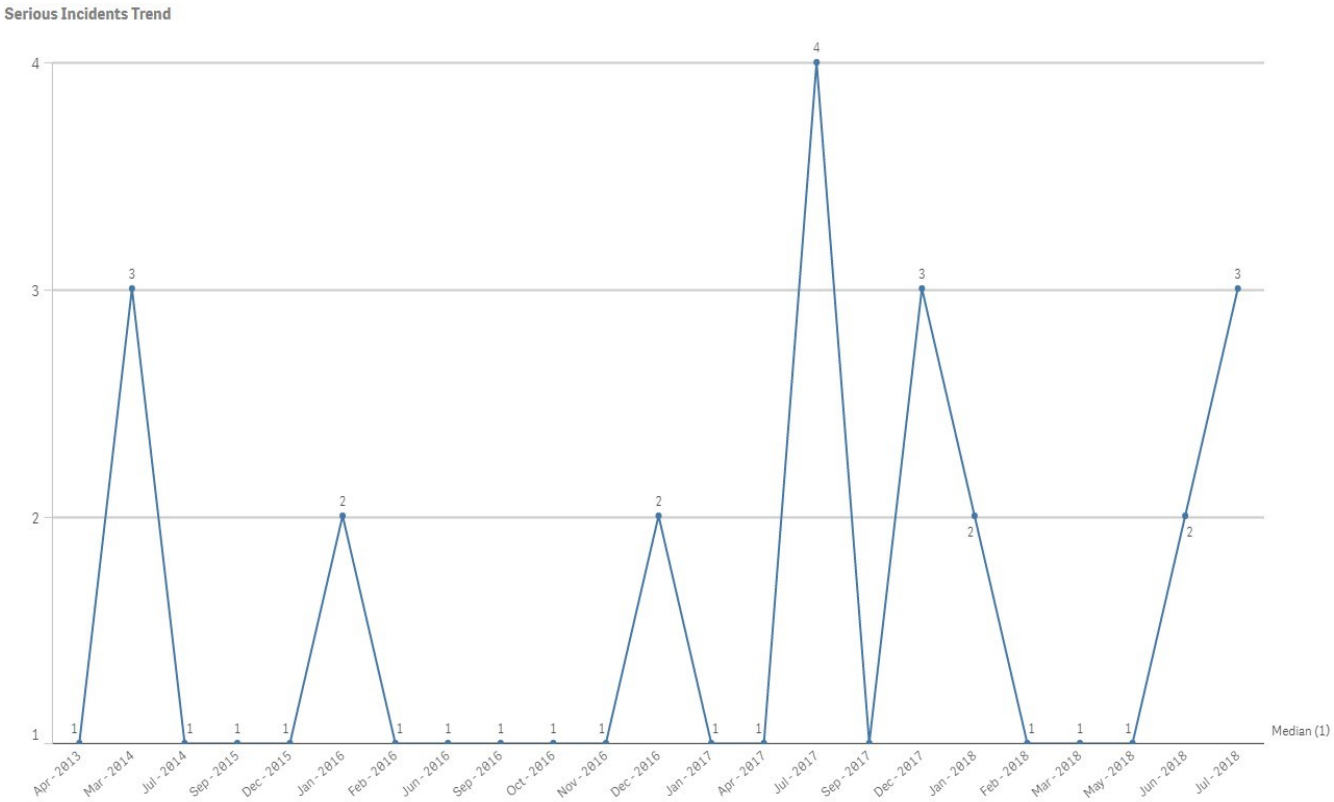
Addressing datix reporting vs actual events is difficult to quantify, as there is a significant variation in how datix reports have been risk graded, with evidence of miscategorisation and lack of uniformity. Therefore, the risk grading system cannot be relied upon. Furthermore, some data fields such as 'shoulder dystocia' for instance is not a field that is currently captured on MITs and therefore, to ensure all events are datixed requires a manual cross reference of all birth registers.

The inconsistent governance processes over the last few years is profoundly evident, particularly when reviewing RCA's, SI's and the number of unreported incidents. The supposed system is extremely difficult to navigate and several reports identified have no linked documentation and action plans to ascertain the whole picture. Furthermore, conflicting or absent documents located in a variety of different folders and personal drives. For example, one action plan was located in isolation for a woman who had experienced a previous SB and went on to have a second SB at term. On reviewing the completed documentation relating to this case, it appeared that the case would be discussed at a clinical risk meeting of some sort. However, no follow-up regarding this case is clear and the actions to be taken forward along with lessons learnt is incomplete. All that is noted within the datix report is that a HB and SOM investigation was undertaken, but again no evidence relating to this was located.

The persistent lack of incident forms and identification of SI's raises concern at all levels and reflects the lack of robust monitoring systems. Figure 2, highlights the numbers of SI's specific to maternity between 2013-2018. It is unclear however, as to why low numbers were not seen as a red flag trigger at Directorate, Corporate & Board level. It is also unclear why staff on the ground did not challenge and escalate concerns to a senior position. From discussing with staff regarding escalation to senior positions this appears to be tainted by the cultural ingrained concerns of what

emanated from Pulse and a fear that their 'registration would be in jeopardy'. Further work to explore escalation of such concerns should be considered, as staff members recently have expressed that historic concerns have been previously highlighted to senior positions within both corporate teams and at Board level, although according to staff *'nothing was done about it…*'. It is not possible to determine what these areas of concern were and to whom they were escalated. Although, if concerns were reported and escalated then this points to another missed opportunity to address system failings.

Figure 2:



5.3 Guidelines:

It was noted within one Q&S Directorate report in 2017 that outdated guidelines were identified by Welsh Risk Pool as an identified risk and it was reported that this was actioned and monitored within the Directorate risk register. An update within the report stipulated that *'the number of 'guidelines were now in date and increasing to over 40%'.*

August 2018 – A manual trawl of guidelines in August 2018 identified 49.5% were either incomplete or out of date. Comparing this to the 2017 report raises the question as to whether processes were in place to ensure guidelines remained up to date. Ascertaining who was responsible for the guideline database was unclear and as a result has recently been absorbed by the clinical risk role. It was identified that this was previously assigned to a Band 7 midwife for a short time, although when changes in roles occurred it was not clear that this was ever handed over. Historically and to date, the guideline reviews have been led predominantly by midwives with no obstetric leads taking ownership. The current and ongoing O&G Action plan includes the

recommendation and action for a Consultant Obstetrician to take ownership for the overview of guideline reviews and ensure obstetric engagement is established. Although, despite escalation of this action, obstetric engagement with this remains poor.

The Morecombe Bay report acknowledged the fundamental need for frontline information to support service provision and was identified as an integral component to support Q&S. A key weakness in clinical governance is when frontline staff along with senior positions do not recognise poor outcomes from clinical incidents or furthermore, are not reported or investigated all together. As reflected within a number of cases through the deep dives and inappropriate closure of incidents.

5.4 Data collection:

The current data collection tool via MITs is bespoke to Cwm Taf and does not support an All-Wales approach to data collection. Various data fields within MITs are missing such as 'shoulder dystocia' and 'elective caesarean sections are not considered as one-to-one care'. In addition, it fails to flag up alerts such as safeguarding and is not reflective of the KPI's as outlined within the strategic vision for maternity services. To work towards achieving a robust All-Wales Maternity IT system for data collection, it is strongly recommended that Cwm Taf should consider the implementation of Euroking ahead of the changes with the SWP. By embedding the National IT system Euroking into Cwm Taf would enable the KPI's to be effectively captured and furthermore, be a step towards supporting an All-Wales approach to data collection. For instance, if Euroking was implemented, then when POW joins Cwm Taf and birth rates increase towards 6000 for the Health Board, this taken together with Cardiff & Vale University Health Board would cover 40% of the overall births for Wales. Furthermore, adopting an All-Wales approach towards data collection would help reduce the data inconsistencies and support an equitable approach.

5.5 Actions ongoing:

In view of the identified failings to report, lack of ownership and poor governance processes, a considerable amount of work has been commenced to address the inconsistencies seen and support the implementation of a seamless and cohesive pathway. Despite an increase in work to ensure better governance processes, this remains a constantly evolving area of work and still a long way from being fully embedded. Particularly around raising the profile further regarding the importance of incident reporting and the escalation of concerns in a timely manner. In addition, senior 8a managers recognising individual roles and responsibilities to act upon datix reviews in a timely and efficient manner. This includes the completion of RCA's in line with the identified timeline.

- Increased training has been commenced with all senior midwives from a quality & safety perspective, with particular focus on datix reporting and the importance of incident reporting. This work however needs to be addressed with all staff members
- A trigger list has been devised and disseminated to all clinical areas. Updates are included within mandatory training and the maternity newsletters.

- Terms of Reference for governance and quality and safety have been devised. This includes a new and evolving structure for governance
- To support the backlog of incidents that have been inappropriately managed and identified, role restructure has been instigated.
- Seconded Band 7 governance midwife out on Trac jobs to address the backlog of the SUI's and support the implementation and embedding of the new governance structures.
- The senior governance lead 8a that is currently a temporary position is also advertised on Trac and interview dates set.

5.6 Recommendations:

- Obstetric job plans to be reviewed to provide support with the ongoing governance structures and not rely solely on the C.D to attend all meetings and disseminate information
- Further work is needed around addressing culture in relation to governance with close attention to working relationships with the CSfM's to support staff with the new structures
- Consideration to initiate regular 'lunch and learn' sessions as a means to support governance feedback sessions and feedback themes and trends. This should be in collaboration with mandatory training.
- Learning outcomes from incidents to be addressed and disseminated in a timely manner
- A MDT datix working group to meet weekly to discuss and act/close accordingly, this will help enable support for one another through a buddy system and ensure a robust MDT approach to clinical incidents
- A lead Band 7 for each clinical area to be supported to undertake datix reviews for their clinical area and SBARs to be completed and feedback to weekly datix review. This will support a robust multi-disciplinary review of cases and provide assurance that a comprehensive assessment has been completed and discussed. In addition, empower staff members with individual professional development.
- New maternity IT system (Euroking) to be implemented, thereby, supporting a robust data collection tool that will support KPI's and ensure themes and trends are being monitored. In addition, this would be a step towards an All-Wales approach to data collection.

Several incidents have been identified where missed opportunities to recognise deterioration in fetal wellbeing. To therefore address whether there is any correlation with babies being born stillborn or with HIE, these areas were further explored as follows.

5.7 Hypoxic Ischaemic Encephalopathy (HIE):

August 2018 - On reviewing the number of cases of HIE across the HB it was identified that there were significant discrepancies regarding the data collected between Badgernet vs the maternity dashboards (see figure 3 regarding the actual number of HIE cases in the HB between 2015-2018 vs what was actually captured on the dashboard). It is assumed that this incorrect dashboard data was then shared with

Welsh Government during the Maternity Performance Board meetings 2015-2017. Figure 3 highlights significant variances in data collection.

In line with the dashboard indicators, data within figure 3 consists of HIE cases grades 2 & 3 only. Figure 4 indicates the total number of HIE cases across the HB (grades 1-3), all data for each figure were sourced from Badgernet. It should be noted that the values for 2018 are of course not yet fully completed and are correct as of the 29th August 2018. Further scrutiny to ascertain if these cases were datixed from maternity is required. Verbal feedback by lead neonatal staff is that datix reporting relating to neonatal admissions are often unreported by maternity, as a result retrospective datix's are then completed within SCBU.

Figure 3 – HIE Reported vs Actual

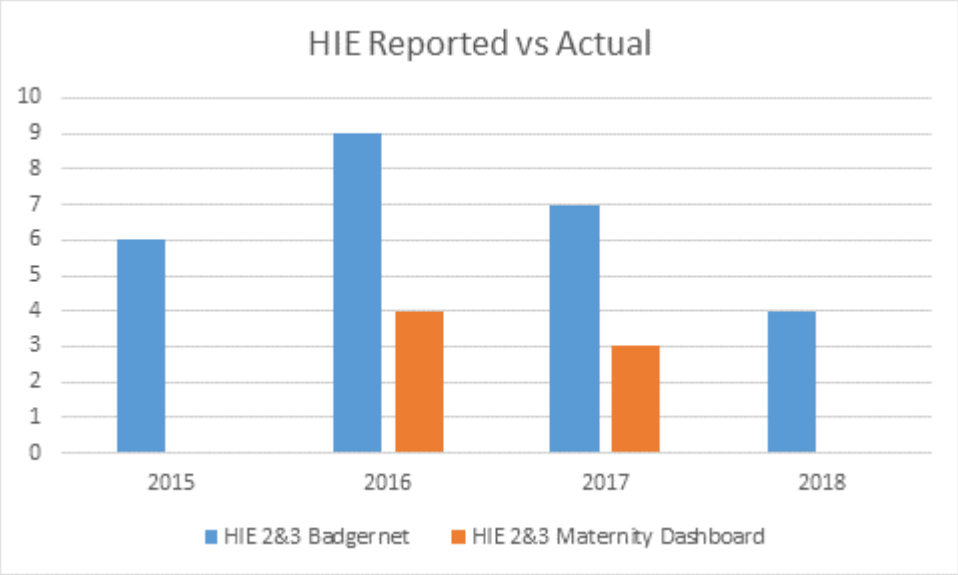
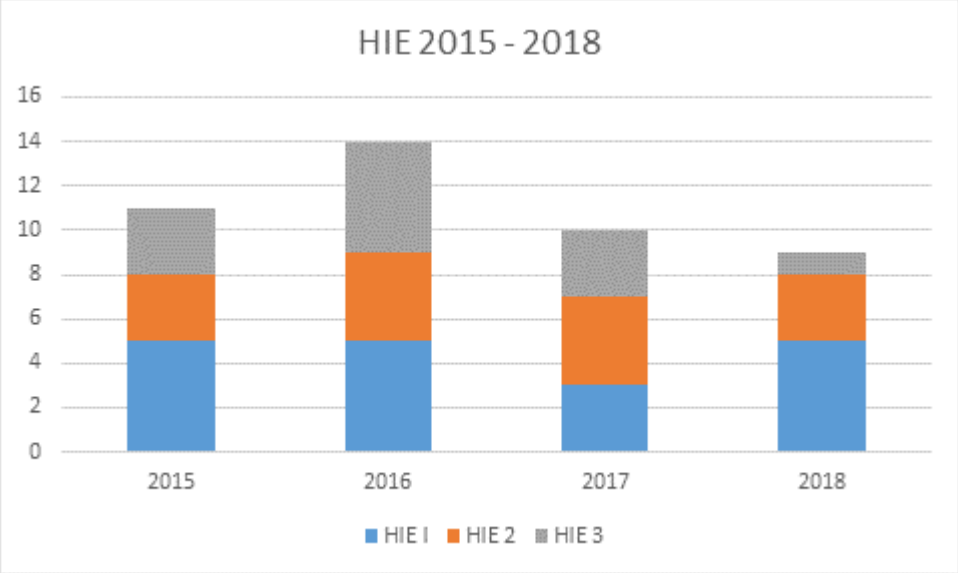


Figure 4 – Total HIE Cases - grades 1-3



To add some meaning behind the data presented in figures 3 and 4, both the MBRRACE and National Neonatal Audit Programme (NNAP) were used to ascertain

whether Cwm Taf was a potential outlier. The table below (Table 2) includes data taken from the NNAP relating to HIE per health board/trust for 2013-2015. Data for the period of 2016-2017 is awaited. The comparator sites used, reflect those within the MBRRACE system as having similar socio-economic characteristics of their population and birth rate. The data presented identified that Cwm Taf had a higher rate of HIE per 1000 births during 2013-2016 than the other units, although this increase did not reach statistical significance. Further work to ascertain whether these rates of HIE are clinically concerning is however required.

Table 2: NNAP HIE Comparator

Trust Name	Total live births	Total live births > 34 weeks' gestation	Number of livebirths with missing gestation	Number of infants born and admitted to NNU with uncertain encephalopathy status	Number of infants born and admitted to NNU with encephalopathy	Rate of encephalopathy per 1000 births (95%CI)
Bedford Hospital NHS Trust	8766	8467	62	0	8	0.94 (0.29, 1.60)
Croydon Health Services NHS Trust	11093	10539	181	54	15	1.42 (0.70, 2.14)
Cwm Taf Health Board	**11424**	**10985**	**36**	**0**	**18**	**1.64 (0.88, 2.40)**
Hywel Dda Health Board	9513	9252	41	8	10	1.08 (0.41, 1.75)

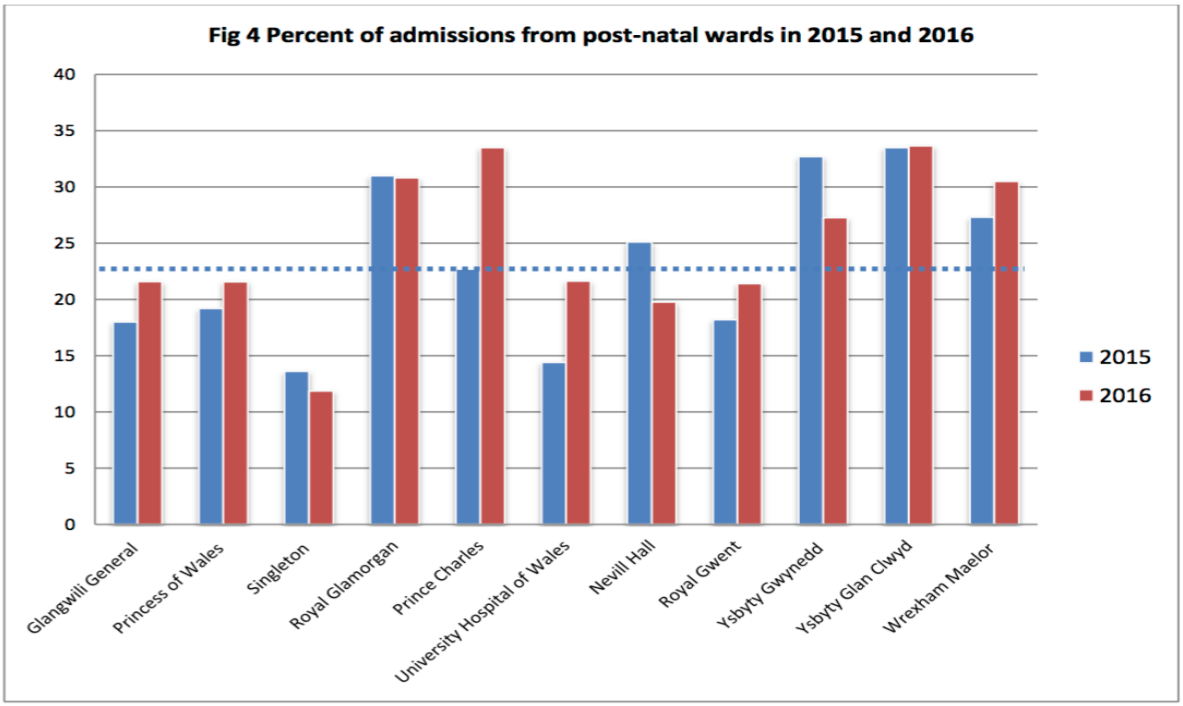
5.8 Term Unexpected Admissions to SCBU:

Concerns around increased rates of unexpected admissions of term babies from the postnatal ward was noticed by the Wales Neonatal Network (2016) as well as through a recent Patient Safety Notice (2018). It was acknowledged in 2016 by the Wales Neonatal Network that Cwm Taf - 'Royal Glamorgan' stood out along with units in North Wales regarding the increased rates of unexpected term admissions from postnatal wards. This was in comparison to all other units in Wales (see Figure 5 & Table 3). Regional variation was noted within the report, although it was requested that each individual unit with increased rates required closer scrutiny, although, it is not apparent that such work was undertaken to address the high rates.

***Table 3:** % of postnatal ward admissions to total admissions 2016 (Wales Neonatal Network)*

Unit	Inborn admissions	Admissions from PN wards	% admissions from PN wards
South West Wales			
Bronglais	9	0	0.0
Glangwili General	244	52	21.3
Princess of Wales	204	44	21.6
Singleton	354	42	11.9
	811	138	17.1
South Central Wales			
Royal Glamorgan	198	61	30.8
Prince Charles	203	68	33.5
University Hospital of Wales	490	106	21.6
	891	235	26.4
South East Wales			
Nevill Hall	167	33	19.8
Royal Gwent	397	85	21.4
	564	118	20.9
North Wales			
Ysbyty Gwynedd	176	48	27.3
Ysbyty Glan Clwyd	214	72	33.6
Wrexham Maelor	164	50	30.5
	554	170	30.7
Total	**2820**	**661**	**23.4**

Figure 5:



August 2018 - Although figure 5 and table 3 is data reflecting the period between 2015-2016, the increased unexpected term admissions from the postnatal ward remains to be a recurrent theme that is reported across both units in Cwm Taf by neonatal staff. This also coincides with the patient safety notice that has recently been issued. A recent snapshot review undertaken by the neonatal development nurse practitioner acknowledged that a frequent occurrence is the failure to complete the NEWTT Risk Assessment Scoring System during labour, which is a framework launched by the British Association Perinatal Medicine (2015) as a means to identify 'at risk infants' and to detect subtle signs of deterioration in clinical conditions. The NEWTT scoring system has been shown to reduce neonatal morbidity/mortality considerably, but currently the risk assessments across both sites are sporadically completed.

5.8.1 Actions ongoing:

- A working group has been established to ascertain any themes and trends and look to benchmark how the rising number can be considerably reduced. Actions from the Patient Safety Notice are also being addressed
- New seconded ward manager (postnatal) is working closely with the Neonatal Practice Development Nurse to support the completeness of risk assessments

5.9 Human Tissue Authority (HTA):

March 2018 – The HTA's third routine inspection of PCH & RGH identified significant shortfalls identified. Their concerns related to consent, governance/quality systems, traceability, premises and facilities/equipment standards. This was the first routine inspection after revised changes to the HTA licensing. Overall, 19 major and 13 minor shortfalls were identified during the inspection which covered mortuary, portering and maternity services. However, significant concerns applicable to Obstetrics and Gynaecology services was evident from the report, this included a lack of training in postmortem consent and no systems in place to ensure regular/refreshed training being delivered. It was also acknowledged that consent from family members had been sought without up to date or prior training. Wider concerns were also acknowledged whereby the Designated Individual was unaware that fetal remains were at times remaining within the maternity units with no oversight of such activities. Furthermore, mortuary staff with a lack of insight into the HTARI reporting requirements.

Concerns around traceability of fetal remains and the limited documentation supporting transfers from the maternity units was also highlighted as a major concern. This was in collaboration with concerns relating to equipment and a lack of standard operational procedures to ensure systems were in situ to safely monitor and meet standards. This included limited awareness around governance procedures including the HTARI reporting requirements.

June-July 2018 – Training for all acute staff including midwives and obstetric staff continues to be delivered, particularly around the gaining of postmortem consent, traceability processes and clear documentation in line with HTA standards. Dedicated time has been provided for the specialist bereavement midwife to take this work forward and to date 63 midwives have been trained. It has not been possible to

determine the ongoing work and MDT engagement in relation to the perinatal mortality review meetings and stillbirth forums, this will require further scrutiny.

5.9.1 Actions ongoing:

- Operational procedures in place to ensure fridges/freezers are checked daily as part of the coordinators responsibility
- Ensure the HTA licensing standards are an integral component as part of the governance structures
- HTA licensing standards to be conveyed to all staff involved in the care of fetal remains

5.9.2 Recommendations:

- Regular audits to take place by bereavement specialist midwife and wider MDT team to ensure safe and dignified care for the deceased are being delivered
- Any learning outcomes from audits should be disseminated through the maternity services communication channels and via mandatory training days

6 Punitive Culture

6.1 Pulse Findings:

October - November 2016: Significant concerns were reported by members of the maternity workforce around feeling 'unsupported', 'vulnerable', 'fearful for their registration' and 'concerns not being appropriately actioned'. This was noted by the Local Supervising Authority Midwifery Officer (LSA MO) as well as during an RCM walkabout. The main issues that were identified related to inadequate staffing levels, allegations of bullying, ineffective leadership and processes around investigatory procedures which were felt to be inappropriate. The escalated concerns pointed to a culture of 'blame' within Cwm Taf maternity services as outlined in the LSA MO action plan. As a result, it was suggested that a Pulse survey should be undertaken. The Pulse survey was felt to be a safe platform and creative space for staff to share their feelings anonymously and was designed by Workforce & OD – 'What's work like for you?' (see appendix 5). At the same time as the Pulse survey, the Director of Nursing provided 'listening clinics', 'Share to Care' surgeries and quarterly meetings were also scheduled throughout 2017 with the previous HoM. Engagement with these meetings requires further exploration, as one report identified that only 1 midwife in attendance.

January 2017: The main themes that emanated from the Pulse questionnaire were in line with what was initially voiced to the LSA MO and RCM i.e.:

- Blame, culture & morale
- Staff shortages
- Management & team support
- Bullying

The overall Pulse response rate was 82 participants which was reflective of 39% of the workforce. Members of staff from both units were represented within the findings

and a variety of clinical areas/skill mix took part. There was a strong consensus amongst the majority of participants regarding the culture being one that was punitive and a service that lacked openness and transparency. The findings also indicated a lack of visibility from the senior team and isolated working.

> *"I feel anxious the majority of the time that I am in work and feel that any small mistake that is made will be investigated. I feel constantly watched and our work scrutinised'.*

Another respondent recommended:

> *"concerns should not be seen as failures and risks should be identified to help improvement. Stop using threat of suspension and disciplinary action over every aspect of the working day"*

The findings demonstrated staff morale was increasingly low with 75% of respondents stating that they did not look forward to coming to work and 82% not feeling valued or appreciated whilst in work. What was further concerning was 26 respondents answered 'yes' to harassment, bullying or abuse by their manager/team leader or colleagues and 1 respondent answered 'yes' to physical violence being received by one of these members of staff. 43 respondents skipped this question, although it is unclear as to whether staff felt fearful to say how they truly felt or whether they skipped it because they had not been exposed to any undermining behaviour. The survey also highlighted that respondents consistently felt disempowered, a lack of autonomy/openness and that the workplace felt unsafe due to the fragility of the workforce.

After receipt of the findings from the Pulse survey which closed on the 6th January 2017, HR clinics were held weekly from the 30th January 2017 providing an opportunity for staff to access one-to-one confidential advice. This was also in collaboration with two HR workshops. To enable improved communication channels between senior management and staff members the commencement of the Maternity Voice Forums were also implemented as of March 2017. These disbanded after minimal engagement.

July - August 2018 – Recent observations and communication with midwives/MSW's, demonstrates increased anxiety across the workforce, particularly around concerns relating to senior members of staff and a 'punitive culture'. The ingrained fear that has been voiced, appears to be linked to clinical incidents and the potential repercussions of reporting. Staff have also expressed the view that the culture has not been a creative space to learn and if practices or behaviours are challenged, then they are *'beaten down with a stick for doing so' or 'you wait for that brown envelope to arrive'*. It is difficult to draw a definitive conclusion around whether this is due to historical deep-rooted concerns relating to the ingrained culture or whether it is the fragility of the current workforce pressures and increasing service demands or anxiety and fear regarding the potential repercussions from certain senior members of staff. What is evident is that midwives appear to have lost their autonomy to challenge and as a result there is a marked lack of teamwork and poor communication. This has also been demonstrated through failure to escalate concerns and the lack of clinical incident

reporting. A heavy use of locum cover amongst obstetric staff is also continuing to add further pressure on an already fractured system.

6.1.1 Actions ongoing:

- RCM 'Caring for You Charter' signed off as of July 2018, this work to continue to be supported and an exploration of ways to expand staff member engagement to be implemented.
- Senior team meetings for Band 7's & 8's to promote inclusivity and a positive team dynamic.
- New governance structures to be clearly communicated with all members of the workforce and further work to ensure embedding of such structures is supported. However, it is fundamental that an MDT approach with obstetric engagement is integral to its functionality. Clear communication around lessons learnt and a clear stance that incident reporting is not reflective of automatic disciplinary threats or actions.

6.1.2 Recommendations:

- Consideration to be given to replicate a 'Prep to Practice model' for all newly graduated midwives/new starters via the practice development midwife (PDM) and CSfM's. It was evident within the Pulse survey and through previous recruitment numbers, that uptake to join the Health Board has been low in comparison to other Health Boards. Furthermore, through the Pulse findings new starters voiced that '*they had never felt so stressed and morale so low'* and '*Band 7 staff stated that they had no time to support newly graduated midwives'*.
- A review of the preceptor and mentor pathway between university and the PDM is paramount, particularly to ensure support provision is robust and a learning environment for student and junior midwives is fit for purpose. This should include regular evaluation of clinical areas, mentors and preceptor mentors. However, commitment from the senior team to support the PDM and CSfM's to facilitate such programmes is indicative for its success.
- Empower senior Band 7's to take on operational ground floor roles and responsibilities (buddy system for support). This will help support the senior 8a manager's workload, but also empower the coordinators to take ownership of their own individual clinical areas. Tight processes however will be required to ensure that monitoring of the service is achieved and should be in collaboration with regular audits and an integrated multi-disciplinary team approach.
- On-call systems to be revisited (Pulse survey highlighted that community staff are felt to plug the gaps for the acute areas). A review of the on-call systems should be considered in collaboration with the new refreshed strategic vision and benchmarking of other health boards. This should also be in collaboration with the capturing of acuity (as per the Birthrate Plus Tool).
- Close working relationships with HR to continue, with a clear pathway to ensuring staff wellbeing is taken seriously. Clear communication channels to promote access to wellbeing clinics to be made available. Corporate wide well-being clinics to be explored as well as any outside third sector support that may be applicable.
- Clear communication at all levels to be embedded and ensure an open, honest and transparent service is delivered. To encourage an open-door policy and

promote positive team working. Explore with staff as to how they wish to be communicated with and consideration for an online MDT forum group with tight governance structures. Evidence to support such communication channels has been noted to be significantly beneficial within other health boards.

- Multi-disciplinary team building days to be considered along with leadership courses particularly for senior members of the team. Service improvement projects as a means to provide assurance to service provision and promote the empowerment of staff.
- Work around changing the culture is indicative for the future success of service provision in Cwm Taf. Commitment at all levels is required to ensure links with experts in this field are made and improvement plans supported to address the 'negative culture' that currently remains.

6.2 Community Health Council (CHC):

February 2018 - A review by the CHC (appendix 6) reported that the temporary maternity unit within PCH was noted to be a challenging environment and felt to be disconnected, particularly with general theatre some way away. The CHC also brought attention to the 'spike in SB's' between December 2017 and January 2018 and requested further explanation regarding this finding. It was also noted within the report that the Obstetrician involved with the CHC review was aware of the increase in SB's, although it was '*felt that this was down to the population that Cwm Taf serves and that he tends not to get involved in this area'*. One is left to question why a senior post-holder did not feel the finding to be of individual importance.

Other factors that were observed and reported by the CHC identified a lack of feedback from patient experience, poor staff morale, lack of obstetric engagement and little communication with the CD:

> *"We were concerned about the apparent lack of communication between the clinical director and the consultants at Prince Charles Hospital. As communication between professionals is essential for the benefit of the women using this service and their families, we would like to receive assurance that this will be investigated"*

The HB's response to the CHC was that 1-1 meetings were said to be in situ along with MDT joint obstetric meetings. However, it would appear that engagement in this area remains poor. One meeting that was observed recently had limited engagement from senior obstetricians, despite dedicated time away from obstetric duties being provided. The response regarding the 'spike' in stillbirths was:

> "*there is no definition for a 'spike' in SB's, but the Health Board would be particularly alarmed if more than two occurred in one month. Every single stillbirth is reported on Datix and reviewed to identify trends, initial concerns and early learning. Wider learning is shared with the team through newsletters and mandatory training".*
>
> It was also reported that, the following actions had also been taken:

- *Safer Pregnancy campaign launched 18 months ago in an effort to reduce the stillbirth rate within Wales.*

- *Multi-professional stillbirth meetings commenced in 2017 and learning is shared through newsletters.*
- *In February 2018, we established a new Stillbirth Forum, which meets monthly. Membership is multidisciplinary across all sites and includes anaesthetists and neonatologists to give a wider review and richer learning.*

As noted from the discrepancies with the datix and SI underreporting, the HB's response back to the CHC highlights significant inconsistencies and failure to recognise that SB's were not all datixed and explored. It is also not apparent that shared lessons were ever disseminated as documented and no evidence of an MDT approach to stillbirth meetings has been located.

6.3 Supervision:

December 2016: An action plan following the LSA MO review meetings identified a range of issues similar to the themes and trends that emanated from the Pulse survey findings: a blame culture, poor staffing and lack of training. The concerns related to both policy and practice can be seen within appendix 7. Discrepancies within this report were identified and again highlight contradictory messages to what was happening at ground level. For example, reported reluctance to escalate clinical incidents out of fear, produced a response that '*datix reporting has always been good within the maternity department'.* This was clearly not the case.

The new model of employer led clinical supervision for midwives (CSfM) came into effect across Wales as of the 1st April 2017. Initially Cwm Taf had a full complement of CSfM's which met the recommended ratio of 1:125 midwives. During 2017/2018 there was noted to be instability within the roles due to retirement and sickness episodes. As a result, the CSfM positions were not up to full compliment. In May 2018, long-term sickness within the governance role occurred and in light of the increased concerns around the lack of governance processes, a request for the CSfM to transfer over to the interim governance role was requested.

July 2018 - Senior midwife seconded to join Cwm Taf from a neighbouring health board to help backfill the supervisory role whilst the current CSfM was seconded into the risk role. To ascertain what CSfM standards had been achieved to date and what action was further required within CT UHB the peer review tool was completed in July 2018 by the new secondee as per the Key Performance Indicators (KPI 6). This was in preparation for the external peer review that is due in September 2018.

On completion of the peer review, it was found that only 3 out of the 22 standards were currently being met across the maternity service (see appendix 8). The staff ratio to CSfM within CT UHB is currently 1:210 due to secondment, sickness and retirement. To bring the service back up to compliment 0.68 of CSfM hours is required, although this will depend on what happens with the new clinical governance positions. A mandated part of the CSfM Model is to ensure all midwives achieve 4 hours annually of clinical supervision, 2 hours of which is to be through mandatory group supervision. Since the implementation of the All-Wales Model in 2017, only two group supervision meetings have been evidenced within Cwm Taf with only a total of four midwives attending between the two sessions. No further arranged CSfM group sessions between October 2017 and July 2018 were scheduled. A database regarding CSfM

hours has been kept, although uptake of clinical supervision appears sporadic amongst clinical areas, and 2017's database is completely empty. On reviewing the database, it is not clear as to whether the documented sessions received in 2018 are one-to-one or group sessions, although feedback from staff is that group supervision sessions have not been made available. Reviewing the data, it is clear that the All-Wales CSfM Standards and Model have not been fully adopted and embedded within Cwm Taf as outlined within the new model (WG 2017). To give some regional comparison, a nearby local health board has achieved 99.9% of its midwives receiving the mandated hours for supervision. It has also become a fully integrated component to support midwive's CPD and annual PADR. When exploring why the new model has not been fully embedded within Cwm Taf to date, it was reported that the previous HoM did not support the new model in its entirety and wanted the CSfM's to remain undertaking an investigatory role. The previous HoM left in December 2017 and there is no evidence to support why changes in processes did not start moving forward then, other than a period of instability with the senior management team and transfer of roles to cover sickness. It is clear from staff feedback and the KPI report that staff have not seen the benefit and value of the new CSfM model until recently and a recent verbal reflection by staff is that CSfM's were previously linked to investigations which reflected a 'punitive experience'.

August - September 2018 – to date 30 midwives have booked group supervision sessions and the one-to-one sessions that staff have accessed since the new changes in July 2018 have already been well received/evaluated.

6.3.1 Actions ongoing:

- Group supervision has been re-established as of July 2018 and dates distributed to all staff by the new secondee. It is acknowledged by the new HoM that all staff should be supported to attend the mandated sessions and should be compulsory when completing PADR's
- Clinical support via the CSfM has been initiated as of July 2018 for all staff members to access and this has been disseminated out to all staff through the newsletter and email communication, as well as visibility within the clinical areas.
- Support with writing statements and accompanying midwives to RCA's/Table Tops have been commenced as of July 2018
- Clinical time spent to date has mainly been within the acute clinical area of PCH due to stretched CSfM resource (previous CSfM's temporarily within the clinical risk roles)
- 0.68 vacancy is required to bring the CSfM back up to full complement (although this is dependent on what happens with the governance roles)

6.3.2 Recommendations:

- All PADR's should evidence that CSfM hours have been met annually, along with evidence of mandatory training achieved. PADR's should not be signed off until fully completed and that includes advancing to the next pay scale.
- CSfM's to ensure 20% clinical component is achieved and evidenced within their individual clinical log (it is not currently clear that this has previously been achieved).

7 Lack of Recognition & Poor Leadership

7.1 Training:

A common theme around training and lunch/learn sessions has been the frequent cancellations and lack of ownership. The facilitation of training across both units has been noted to be a significant challenge and has been predominantly left to the PDM to coordinate all training. However, despite regular mandatory training sessions being implemented and planned, frequent reports of non-attendance from faculty members at the last minute has been documented along with poor engagement. It is evident that cancelling training due to poor staffing has become the norm and it suggests a lack of acknowledgment from senior positions regarding the importance of CPD. The persistent lack of commitment to training and the lack of recognition that CPD is an indicative component in assurance of service provision further demonstrates a culture that does not value.

A training log and database kept by the PDM reflects the numerous cancelled sessions and lack of engagement across the MDT to date. Reasoning behind cancelled sessions or unfacilitated sessions are as outlined above and reflect the same reoccurring themes. Current staffing levels as of September 2018 remain fragile and are an increasing challenge to coordinate. Priority to courses such as NLS have been facilitated, although, the long-term sustainability with two units on skeleton staff remains a continual concern to ensure training is delivered. Due to staff fragility, daily fire-fighting of staffing issues remains. A rolling advert for Band 5 and 6 midwives is ongoing and 6 WTE vacancy offers have recently been secured. This leaves a further 14 WTE midwifery vacancies currently open.

It is reported that audits across both units are undertaken and that an obstetric lead is identified, although, further work to ascertain how streamlined this process is and the ongoing audit programme agenda is required, as this is not currently evidenced or appear to be facilitated (September 2018).

A recent Deanery review of the trainees was reported to be ‘positive’ according to an email trail received by the Medical Director. Although, it is unclear as to how many trainees this review included and is a very different picture to what is currently being expressed by some registrars on the shop floor. It has also been acknowledged recently (April-to date 2018) through a number of incident reports that Consultant leads have not been adhering to their contracted ‘40 hour labour cover’. As a result, have not been readily available for obstetric emergency support. Bleeps have now been given to all consultants, although on occasions despite the bleep system being in situ, failure to answer or attend in a timely manner has been noted.

7.1.1 Recommendations:

- An obstetric lead to be identified within job plans to support the ongoing training needs and not rely solely on the C.D to attend all meetings and disseminate information. This should include all areas of training and development
- MDT training sessions to be provided with the commitment from all faculty members

- Specialist areas to take ownership and facilitate reoccurring lunch and learn sessions for all staff to attend
- Obstetric trainees to be empowered to take working streams forward as well as opportunities for junior midwives to develop

7.2 PADR Compliance:

It was noted within a Directorate Q&S report that PADR's in May 2017 was 43.94% compared to the Health Board target of 85%. It was further reported by the previous HoM that '*plans were being developed to ensure compliance was met and that through the monthly CBM this would be challenged by Execs to increase this'*. However, compliance as of April 2018 was identified by the new HoM as 41.3% a further decrease in comparison to the previous year. Compliance is now 85.75% and plans in place to meet the next annual targets.

7.3 Growth Assessment Protocol (GAP):

The implementation of the GAP protocol commenced around May 2016 and was led by the senior midwifery Risk Manager. From reviewing the work relating to the implementation of the tool, the role included the coordination and chairing of all GAP meetings, coordination of training sessions, embedding the tool into clinical practice and identification of 'GROW champions'. This was in addition to the other several roles and responsibilities that the Risk Manager oversaw. The suggested vision for the GAP working stream was for quarterly meetings to be held with the identified champions, which was deemed to be the most appropriate and efficient way of monitoring the ongoing work. On reviewing the GAP/GROW documents, a number of templates were noted amongst various files, but there appeared to be an increased number of incomplete action plans with no sequential order and no assurance that the actions were ever implemented into practice. Only two action cards were located relating to quarterly GAP meetings and one log regarding a GAP Workshop, both of which were undertaken in 2016. The actions identified within 2016 centered on the need to disseminate training and the importance of identifying 'GROW champions' to take the work further forward. Since then, no agendas or minutes for further GAP quarterly meetings have been located.

7.3.1 GAP/GROW Training:

To ensure all champions (midwives & obstetricians) were trained appropriately, attendance to the Wales wide Perinatal Institute regional study sessions were encouraged (June 2016). Initially, a persistent lack of engagement was seen until concerns were escalated to the previous HoM. Uptake from some midwives did subsequently improve, although poor engagement from Obstetrics remained, with only one Consultant Obstetrician registered to attend. A local action plan following on from the Wales wide study session included for the appointed champions to disseminate the lessons learnt operationally, although, it is unclear whether this was ever facilitated. Furthermore, it does not reflect current practice with the significantly high IOL rates for 'tailing off growth', inconsistencies with serial scans/SFH measurements and the missed opportunities with decreasing Stillbirths/IUD's. The turnover of GROW champions also appears uncertain and training ad hoc. E-learning applications for GAP/GROW were apparently uploaded to the clinical intranet in 2016 to support staff,

although staff participation with this is unknown and as of September 2018 the apps that were requested by the GAP/GROW lead could not be located. It is therefore, unclear as to whether these were ever uploaded. A local in-house study session in January 2017 was also organised for champions to attend, although again it is not known as to how well attended this was or if it was delivered.

November 2016 – It was noted by the GAP lead within one email communication that an increase in unexpected SGA babies were identified through datix reporting. To enable this to be explored further, the labour ward lead was assigned the ongoing work via the lead for GAP/GROW and previous HoM. This however, questions the robustness of the actions and structure that were supposedly already in place through the GAP Champions and GAP/GROW quarterly meetings. In addition, raises questions as to why unexpected cases of SGA babies weren't already being monitored including the auditing of birth centiles. A further request for GROW champions was also requested through the same email communication, although this does not correlate with the correspondence that was made four months prior, which indicated that champions were supposedly already allocated.

April 2017 – A further request for GROW champions within the community was made along with a noted trend that community was an area where further training was required. Although according to both the 2016 and 2017 GROW Champion staff lists, allocated champions appeared to have already been identified. In light of these repetitious requests it questions what ongoing work was actually taking place in relation to the working stream.

It can be concluded that the implementation of the GAP/GROW tool into clinical practice has been inconsistent and the following of the GAP/GROW risk criteria not adopted. This is demonstrated through the lack of obstetric engagement with the risk assessment criteria for serial scans, no allocated professional overseeing the birth centiles and the increasing IOL rates for "tailing off growth". Prior to June/July 2018, serial scans did not reflect recommended guidance of 2-3 weekly USS measurements and scans were ceasing at 37 weeks' gestation up until recently. There remains considerable variation with what obstetrics are requesting in terms of 'serial scans' and this has resulted in unnecessary medical intervention alongside a poor reflection of working prudently. Furthermore, the ceasing of scan measurements at 37 weeks, has significantly increased the number of unnecessary IOL at early gestation. This also correlates with the activity and impact that both SCBU's are currently seeing with the number of increased unexpected term admissions.

June 2018 – High rates of IOL rates were noted by the newly appointed Consultant Midwife. This was identified when addressing and exploring the low numbers of women accessing MLC and addressing the rationale behind why this was happening. It was clear that the increasing numbers were frequently related to 'tailing off growth' and the misuse of the GAP/GROW tool. The challenges relating to the GAP tool that were reported back in 2016 remain the same to date and have been repeatedly noticed. These have included:

- Inconsistencies around SFH measurements
- SFH measurements at the same time as serial USS's
- Ad hoc 'serial scans' that do not fit criteria

- Women referred for serial scans outside guidance/criteria
- Serial scans stopping at 37 weeks gestation

7.3.2 Actions ongoing:

- A new working stream launched to address the high numbers of IOL
- Benchmarking of two local health boards that have GAP/GROW almost fully embedded has been completed
- GAP guidance currently being revised and based on the benchmarking of two local units that have evidenced a significant drop in SB rates
- MDT engagement encouraged, CD present – although no other obstetric colleagues engaged at present
- Revised serial scan chart following the risk criteria of minor/major (to be implemented October 2018)
- Radiographer undertaking a snapshot audit of the number of increased and unnecessary scans coming through
- The extra scan resources to meet GAP requires further consideration, discussion and work around this has been commenced within the working stream
- IOL audit underway
- Fetal surveillance midwife required to support the assurance and ongoing monitoring of GAP service provision. This is fundamental to ensure that the evidence is available to support quality improvement.

7.3.3 Recommendations:

- Engagement with the new guidance and criteria requires full commitment across the MDT and will require regular training and audit to ensure that GAP is being utilised as it should. To date, the themes and trends acknowledge that engagement has been poor with change so robust processes for monitoring is indicative of its success

The ultimate goal of GAP is to identify babies at a higher risk of stillbirth and decrease such risks through better surveillance. From reviewing the documents, templates and sporadic meetings, the implementation of the GAP tool appeared to start off with momentum with the vision to hold quarterly meetings to support the ongoing assurance of the work, although as seen with the majority of working streams that have been reviewed, there has been limited structure and ownership. As a result, this has had considerable impact on clinical practice and unnecessary medical intervention of birth.

7.4 Lower Segment Caesarean Sections/Induction of Labour (LSCS/IOL):

LSCS and IOL rates have continued to increase to almost double the recommended WG targets over recent years. The increasing numbers have been acknowledged by the HB as well as at WG level through the data presented via the Maternity Performance Board Meetings and Directorate reports. The same reoccurring concerns however, have been documented as far back as 2015 particularly challenges with

implementing GAP/GROW and the rising LSCS/IOL rates (see appendix 9). However, despite the rising numbers being identified as a red flag, the work remains 'continuously ongoing' and little evidence has been identified to support this 'ongoing work'. Furthermore, both the IOL and LSCS rates have continued to soar with some of the highest numbers seen within the early months of 2018 (see figures 6 - 8). This is despite the Directorate's commitment in addressing the increasing numbers, as outlined within the 2016 Q&S Directorate report;

> *'the directorate remains mindful of the need to reduce CSR and IOL rates to maintain the rate below 25 % (LSCS) and 20% (IOL) as per the WG target'*
>
> *'by supporting all low risk woman to provide care in a midwifery led environment in line with the WG target of 45% will also help to assist with the reduction in CSR'.*

Figure 6:

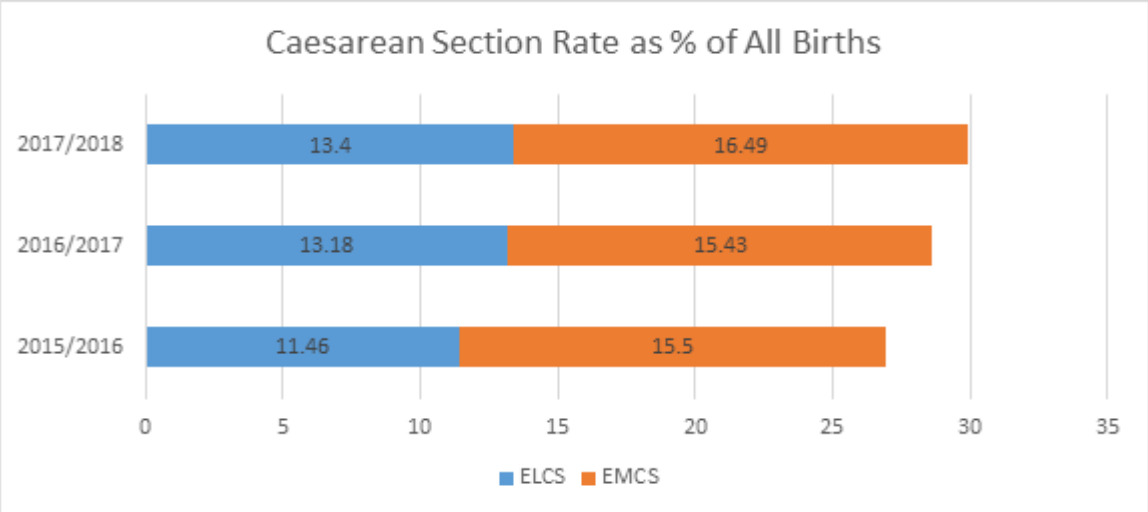


Figure 7:

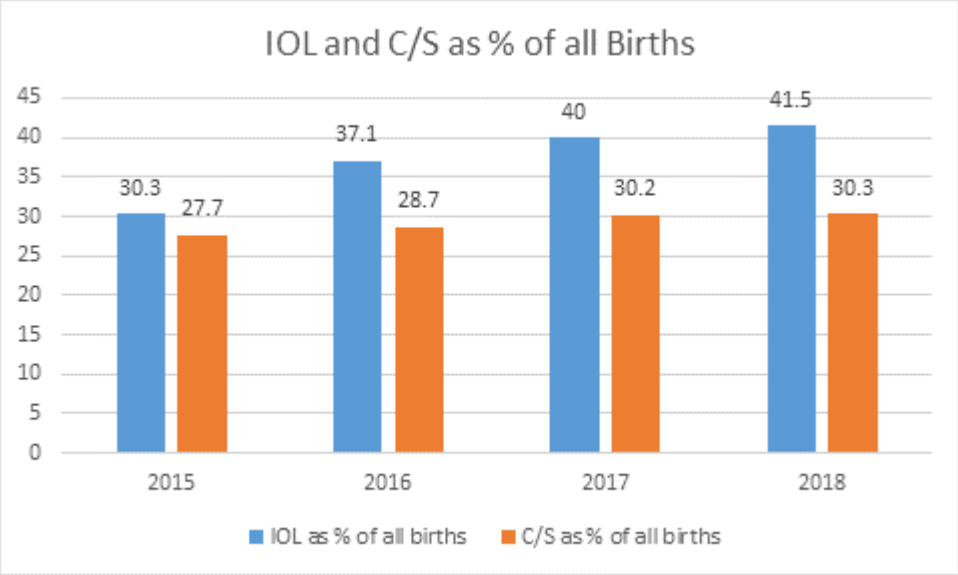
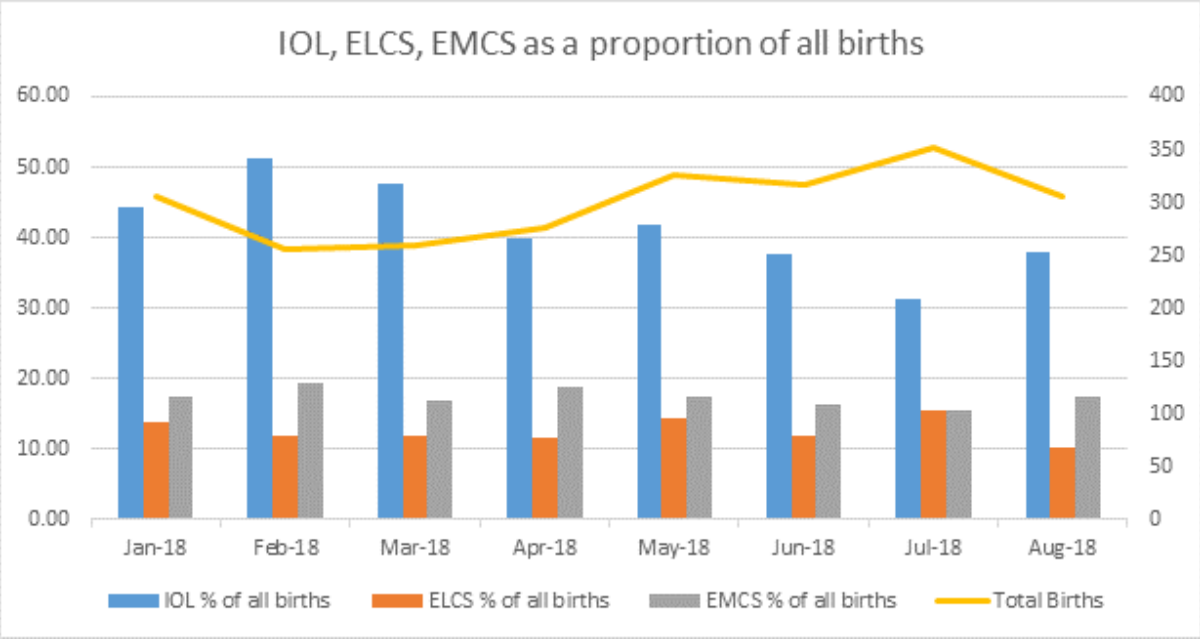


Figure 8:



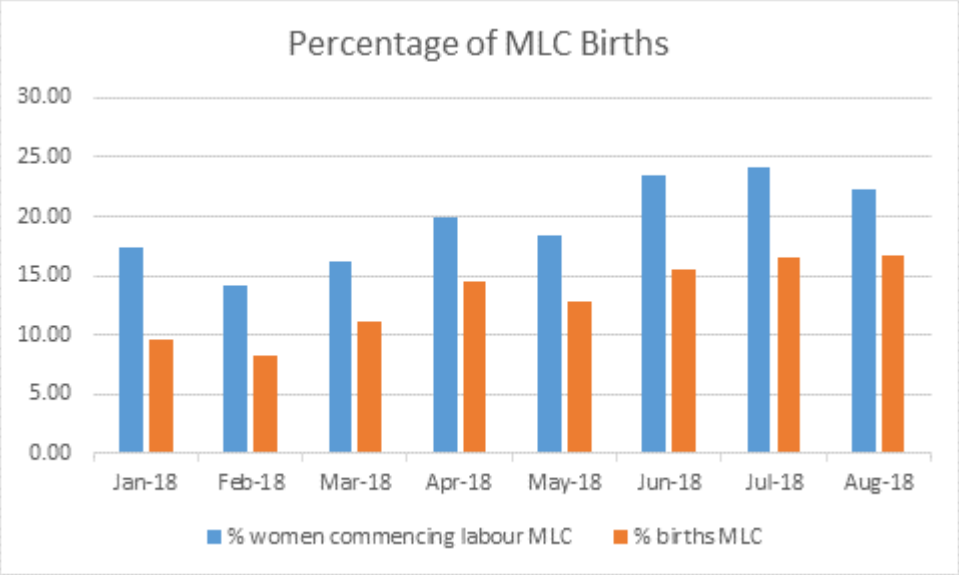
It was recorded within the 2016 Directorate Q&S report that the 'Senior Management Team' would action the rising numbers of IOL & LSCS rates and that it would remain an area for discussion at each Maternity Performance Board (MPB) meeting, Directorate Q&S, HOMAG and WG meetings. Despite it being discussed at the annual MPB meetings with WG and the Directorate's commitment to address the increasing numbers, it is evident that this work has not been implemented operationally. It also remains unclear whether the Directorate Q&S meetings are ongoing as no follow-up reports have been identified since 2016, again, suggesting a lack of uniformity to Q&S processes.

7.5 Midwifery Led Care (MLC):

It was noted within the Directorate 2017 Q&S report that a strive towards the prudent maternity care target of 45% of women commencing birth outside of a CLU would help in the reduction of IOL and LSCS rates. It was also reported that the Alongside Midwifery Led Unit's (AMU) were '*fully functional within both acute maternity sites*'. Although, the rising numbers of medicalised births would question the long-term impact on the success of these units. Figure 9 indicates that CT MLU's are some way from reaching the WG prudent maternity care target of 45%.

A lack of belief in the ethos of MLC from certain obstetricians across the service has also been noted through feedback from staff and is reflective of the increased medicalisation of birth. This raises questions regarding the true informed choice that women are making. It also raises significant concern for the future impact on the new maternity model in line with the SWP. Engagement and commitment from Obstetricians is necessary for the MLU's success and is pivotal to the Q&S of services, particularly with the changes that Cwm Taf are to see in March 2019.

Figure 9:



Taking into account the increasing numbers relating to LSCS, IOL and MLC it would appear that CT UHB is an outlier and a significant way from achieving the 45% prudent maternity care target. However, further work to explore the local data from a national and regional perspective is required.

7.5.1 Actions ongoing:

- Modernising of antenatal clinic infrastructure
- Addressing GAP through working stream
- RAG system for booking awaiting implementation, moving away from CLC being the default option

7.5.2 Recommendations:

- Revisit community antenatal visits as per GAP and NICE guidance (training resource required)
- Secure the staff that will be taking the AMU & FMU work forward, once agreed intensive work to be completed with all members of staff. Including skills drills and buddy working systems with other units. Assessment forms for all areas of care to be completed in time of the launch.
- MSLC to be reviewed with appropriate terms of reference (Lay chair to be appointed)
- Address continuity of carer and follow up with staff undertaking audits to support that this element of care is being achieved
- Review birth choice clinics
- Joint clinic between Consultant Midwife and a Consultant Obstetrician for women who may fall outside recommended guidance and request MLC are reviewed

8 Interdisciplinary Working

It is evident from the findings that have already been presented, that working in silos is a persistent theme and one that highlights a fractured system. A lack of ownership, communication and MDT engagement is apparent. Fragility of the workforce has also been a persistent challenge over the years, from sporadic incident reports and frequent cancellations of training. A clearer understanding regarding staffing numbers and gaps within rosters will require further scrutiny.

8.1 A fragile workforce:

February 2017 – Following a review by the CHC, the HB's response indicated that the workforce was up to full establishment and Birthrate Plus (BR+) compliant, which included the 'additional funding to support the decant'. Although, this differed to the LSA MO's report which acknowledged in December 2016 (two months prior) that the BR+ assessment was significantly outdated and several years old. Conflicting reports regarding the acuity tool being utilised was also noted and as a result questions the value and accuracy of the devised action reports. Between the period of 2012 to 2018, it has been reported that no service acuity was collected to support safe staffing levels in conjunction with increasing or decreasing service demand. It is therefore difficult to ascertain and draw conclusion that the service demand was and has been met with safe staffing levels, particularly if the acuity was never recorded. Furthermore, the picture that has been fed back by staff on the ground and the fragility of the current workforce has reflected a very different situation to the one that was reported within various documents. The lack of acuity reporting and previous underreporting of clinical incidents is again a significant concern, particularly as assurance was being provided that the service was one that was safe and BR+ compliant. Although, the inconsistencies identified suggest that this has and continues to be a patient safety issue.

It was also noted within the HB's response to the CHC in February 2017 that Cwm Taf had no difficulty in recruiting and retaining midwives, although, this was a different picture to what was reflected within January's 2017 Pulse survey findings. It was also acknowledged that all newly graduated midwives were supported by preceptor midwives and CSfM's. However, the effectiveness of this supposed preceptor programme was indicated within a 2016 RCA to be sub-standard and not fit for purpose. Furthermore, CSfM's were not supported to undertake such a role as recommended within the new CSfM vision. The Pulse findings also reflected a different picture the month prior, where Band 7's reported that they had no time to support junior staff and junior staff reported that they had '*never felt so stressed and morale so low'*. The reports therefore highlight a number of inconsistencies and do not demonstrate the reality of the concerns which were raised in January 2017.

May 2017 - The UHB response to the CHC monitoring report outlined that RGH had additional midwives to support the service provision and over the '*last 6 months staff had expressed more positively regarding things'*. However, it is not clear as to where this information was gathered from and is not reflective of the findings that were found within the January 2017 Pulse Survey report. A request for staffing figures between January and May 2017 has been requested to cross reference.

April 2018 – Significant variation regarding staff vacancies was identified through the newly appointed HoM. This was uncovered when addressing the new service reconfiguration model. An incomplete live staff database was located by the HoM and disparity regarding overall vacancies was stark. The reported vacancies amongst senior managers varied from anything from '10-30 posts' with no definitive answer. Although, either figures highlighted that the service was evidently not BR+ compliant as it was made out to be. It remains unclear from both finance and the uncompleted database whether Cwm Taf was ever BR+ compliant as suggested through several reports. As conflicting reports to MPB have been located by the HoM which indicated BR+ compliance when the service was 6 WTE vacant. It is unclear as to why these figures did not correlate with what was reported or whether this was another failure to recognise.

9 Conclusion

It is evident from this review that systemic failings in the maternity service have existed for several years, and continue to be ongoing. These have resulted in poor clinical care, inadequate reporting and missed opportunities for improvement.

The review demonstrates a persistent lack of MDT engagement, ownership, leadership and several examples of 'working in silos'. Furthermore, the absence of clear governance structures and quality safety processes are stark. Some of the challenges and concerns highlighted through this report are a repetitious theme that have been illustrated across reports, sporadic action plans and SBAR's by both senior management and directorate. Evidence of actions being implemented operationally along with ensuring a creative space for staff to learn is noted to be significantly lacking. This is evident through the increased numbers of failure to report, the increasing IOL/caesarean section rates and the missed opportunities in recognising deterioration in health and wellbeing of both mothers/babies. Reoccurring themes identified are as follows:

- A lack of any sequential pattern to action logs
- Ad-hoc meetings
- No clear terms of reference or set quorum for MDT meetings (particularly Q&S & Governance)
- Poor data collection and acknowledgement of what the data means (no insight into themes and trends)
- Ineffective systems to follow-up action logs and clinical incidents (no acknowledgement at corporate and Board level regarding the low numbers)
- No clear effective governance structures or central database
- Ineffective leadership/ownership and lack of engagement
- Persistent working in silos at all levels
- Lack of CPD and research implemented
- Failure to escalate
- Failure to embed and disseminate lessons learnt or brief rudimentary lessons
- No uniformity to investigatory procedures
- Dysfunctional team working
- An ingrained punitive culture

It is apparent that new initiatives or changes to service provision have lacked a robust systematic approach. The GAP protocol started off with momentum, although this was noted to be governed and led by one individual who was also the lead for several other projects. With a catalyst of senior roles for one individual to undertake, this has resulted in no clear review mechanisms or systematic processes to support quality improvement and assurance.

It is also clear from the findings that there was a persistent lack of insight at all levels regarding themes and trends relating to datix reports and SI's. In addition, there have been missed opportunities to reduce poor avoidable outcomes by ensuring a systematic process was embedded to address areas of concern and cascade lessons learnt.

A frequent finding when exploring the ineffective process around clinical incident reporting was, incidents repeatedly not being reported on, limited or no action plans following review, miscategorisation of incidents and RCA's undertaken with no evidence on datix. This raises significant concern regarding the lack of robust governance structures and poor leadership. However, it also reflects another missed opportunity by the corporate team to cross reference and question regarding the low numbers of datix's seen within maternity. The inappropriate closure of datix cases also demonstrates the absence of collaborative working and regular engagement meetings at corporate and Board level. Such closures should have been authorised and undertaken by corporate patient safety to provide assurance that appropriate action and management had been taken.

The reports used to support the evidence for this review, often appear to be misleading and conflicting with regards 'update of progress and compliance'; as there appears to be no reflection of operational change or sequential follow up to actions or learning outcomes. As a result, reoccurring themes and raised concerns around learning outcomes have been repeatedly seen on an annual basis; leaving the service open to increased liability and scrutiny. Deciphering the data and organisational processes and structures has proven to be extremely difficult to explore, due to the poor coordination of systems and instability of leadership/ownership in driving agenda's forward. Furthermore, the frequent changes in ownership along with a lack of commitment/continuity to see projects fully implemented was profoundly evident.

If some of the action logs or annual reports were to be used in isolation, it could appear as if systems were in place to reflect organisational process and a means of providing assurance. The detailed action logs, reports and dashboards all demonstrated and reflected compliance with certain standards over the years. However, it was evident on cross-reference that there were significant discrepancies with regards data collection as noted when comparing Badgernet with the maternity dashboard and datix's with MITS. Furthermore, there was no sense check on the data captured, which is paramount to ensure quality assurance. This was also supported through both the Francis and Morecombe Bay reports, where it was acknowledged that data should not just be collected for the sake of collecting data.

It is evident that some of the concerns highlighted within this review have been previously acknowledged at all levels and although action steps have been called for

over the years, failure to follow this up and implement/embed change into practice remains a common theme. There were several sporadic action plans and SBAR's devised, including an action log in response to the failings identified within the Morecombe Bay enquiry. However, despite the detail within the reports, the reality of the situation appeared to be lost and over shadowed by the deemed 'successes'.

It is fundamental that governance structures are embedded into a department to provide assurance to service delivery. Although, putting the principles of good governance into clinical practice is everyone's responsibility, robust systems and leadership are paramount. However, this also requires a commitment from all members of the MDT particularly obstetric and senior support.

Taking into account the level of systemic failings identified this raises the question as to why this has not been previously identified by senior members of the Health Board. The ingrained 'punitive' culture that has been heavily intertwined across all the findings is reflective through the persistent lack of collaborative working, a dysfunctional senior team, no creative space to learn and a lack of insight as to what has been happening at ground level. This is further evidenced through inaccurate data collection, lack of incident reporting and significant variances within detailed reports.

10 References:

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Kirkup B (2015) The report of the Morecombe Bay investigation. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf (accessed 25/08/2018).

Mothers & Babies: Reducing Risk Through Audits & Confidential Enquiries across the UK (MBRRACE) (2018) Perinatal mortality surveillance report, UK perinatal deaths for births January 2016 – December 2016. Available from: https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Perinatal%20Surveillance%20Full%20Report%20for%202016%20-%20June%202018.pdf (accessed 26/08/2018).

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Welsh Government (2017) Clinical Supervision for Midwives in Wales. Available from: https://gov.wales/docs/phhs/publications/170519clinical-supervisionen.pdf (accessed 2/9/2018).

11 Appendices:

Appendix 1:

Datix Review Flowchart January 2

Datix review process and action

Appendix 2:

Datix Deep dive revised version 2.do

Appendix 3:

SBAR MBRRACE-Each Bab

Appendix 4:

Morecombe Bay Action Plan Cwm Taf

Appendix 5:

Maternity Survey Part I - What's Work

Maternity Survey Report Part II 22 Ma

Appendix 6:

Action Plan PCH - Maternity Neonatal

Appendix 7:

LSA action plan 2016.doc

Appendix 8:

CSfM Peer Review Self Assessment 170

Appendix 9:

Q& S Directorate Meeting September

Appendix 1

Flowchart for Datix review – Acute Services

review of all Datix must be completed within 2 weeks. If further action is required completed date to be agreed with the RM and Investigating Officer.

Initial action

1.Datix submitted

2. Datix received by Risk Manager.

3.Moderate / Severe harm action review by RM / Senior Midwife . (e,g HIE / Brain cooling)

4. If appropriate- Low/ No Harm ward lead to complete review report and action directly on Datix system. (this will avoid duplication but can still be monitored via RM). See suggested list for direction.

5. Completed review report to be returned to Risk Manager for Datix closure.

Weekly action

Ward leads to obtain the notes for review please.

- ✓ Weekly Datix meeting with HOM & RM to discuss recent / ongoing Datix.
- ✓ Weekly Datix meeting PCH Monday RGH Tues with Senior Midwife/ Ward leads/ SOM / RM / Other professionals to review new and ongoing Datix. Ward leads to ensure notes are available prior to the meeting.
- ✓ Review reports to be completed at the meeting. The completed reports to be sent to RM by Wednesday each week.
- ✓ RM to attach reports and close Datix if appropriate.
- ✓ Any action to be completed by the appropriate leads

Closing the loop

- ✓ RM to populate weekly trends / themes and circulate the newsletter to all areas / staff.
- ✓ Updated Datix database saved to Managers file.
- ✓ Updated Datix database sent to all professionals for information and monitoring.

Approved January 2017 Review January 2018

Datix review and action Pathway 27th April 2017

Datix is submitted.

- All Datix forms are reviewed in a weekly multiprofessional review meting.

PCH Monday 12.00 – 13.30 hours. Senior Midwife Office.

RGH 12.00 – 13/30 hours. LW office.

Local learning identified –

- Complete HB review form.
- Form sent to Senior Midwife Risk.
- Datix closed.

- CsFM to share in mandatory training
- Themes shared in PROMPT
- Place on lessons learnt newsletter.

Issues identified relating to NMC Code.-

- Reviewers to complete HB Review form – Issues relating to NMC code.
- Suggest possible action / learning.
- Senior Midwife Risk to share with HOM/ CD.

- HOM/ CD and Senior Midwife Risk to discuss and agree proposed action / way forward.
- HOM / CD & Senior Midwife to complete & sign HB Review form relating issues to NMC code.

If there is previous history of practice issues.

This evidence in available in the personal files.

Line manager to be informed.

- Discussion with HOM/ CD/ HR & Line Manager.
- Meeting to be arranged to agree a way forward.

The Health Professional to be made aware by the Line manager / HOM.

Capability/ Disciplinary processes to be processed.

No previous issues related to practice

Pre-capability / disciplinary action plan which will demonstrate learning / reflection to be agreed with clear objectives and time limits. The action plan to be agreed by the HOM and shared with the Line manager / CSfM

Member of staff to meet with Senior Midwife Risk.
Action plan & time limit discussed.
Support offered by CSfM.
Informed this is a HB pre capability / disciplinary process.
Not supernumerary status.

By the agreed date

- Senior Midwife Risk to examine evidence of learning. Sign off evidence.
- Completion letter to be sent to professional. Explanation that if a similar incident happens capability/ disciplinary process may be commenced.
- Documented evidence to be produced to the HOM.
- Final sign off agreed by the HOM .

Issues unclear-

Multiprofessional tabletop to be arranged.

Senior Midwife Risk to support this exercise.
Consultant Obstetrician to lead.
Notes to be shared with HOM/ CD.
Further action to be agreed depending on discussion / reflection received during the exercise..

No further action -
All documentation to be placed in the personal files of the professionals involved.
Further action will depend on agreed

All documented evidence to be placed in the personal files.
The line manager to be informed at every stage of this process
Staff support is offered to the member of staff at all times.

Datix Review of all Datix between March 2017-September 2017.

Situation
Following concerns surrounding the process of datix reporting, investigations and lessons learned, it was agreed a review of maternal and neonatal events reported between March 2017 and September 2017 would be undertaken, to provide assurance that incidents were reported and investigated within the Cwm Taf governance structure.
Background
Serious incidents found and not reported on the Wednesday 30th may 2018, review was conducted by the senior Midwifery team and included some reviews by the Clinical director. - Datix reporting was below expected averages within maternity, taking into account the number of datix reported throughout maternity units in Wales, range was between 40-120 a month, the higher number reported on more births. - RCAs were found linked to Datix reports, these were incomplete, corporate governance had not signed these off and actions taken had not been evidenced. - No evidence on Datix of statements, feedback or action taken to address individual practice. - Senior Team Some of the Senior Midwifery Team did not demonstrate an awareness of governance processes, one member did not have access to Datix, another informed me she was told this was not within her role. Two members of the senior team have emails demonstrating they escalated to the HOM and never received feedback. No evidence on Datix on feedback being given on any of the cases reported.

- At the same time of the deep dive review investigation commencing the governance midwife became absent from work due to ill health and remains so at this current time.
- Lack of clear process Lack of evidence to support reviews on outstanding Datix, concerns or complaints.
- Lack of MDT approach to governance, the process of governance was kept between two individuals and did not include medical team, corporate governance or directorate managers. No evidence on Datix of a review or medical opinion.
- Governance Midwife verified all Datix and no internal verification from corporate governance team was sought
- This period was chosen as the new model of Clinical supervision came into effect, which meant supervisors were previously employed by Welsh Government, the new role meant they were then employer led with a change to scope of practice.

Assessment

A deep dive was undertaken, using 68 notes pertaining to both maternal and neonatal events which occurred between March and September 2017., appreciating that the review was based on incidents reported, rather than total women cared for, during that period. 34 maternal events and 34 neonatal events selected from those reported onto Datix

findings showed that:

- 2/34 unreported Serious Incidents regarding neonates sent for cooling,
- 7/34 episodes of poor resuscitation of the neonate, these included failure to act, failure to escalate in a timely manner and failure to follow resuscitation guideline.
- 5/34 episodes of poor documentation, questions were raised surrounding care given and unable to answer as no statements available.
- 9/34 episodes of lack of escalation in a timely manner resulting in a delay of care by the appropriate professional.
- 6/34 episodes of CTGs being categorised incorrectly, resulting in two neonates sent for cooling as born in poor condition at birth, no adverse outcome for others.

- 4/34 episodes of inappropriate use of Fetal Scalp Electrode as a first line action to improve CTG, this is not evidence based and resulted in a further delay in appropriate care.

Immediate actions taken included:

- 3 table top reviews due to lack of investigation or robust process for ensuring lessons learned
- Embedded MDT approach to review of all incidents reported
- Training for band 7 and senior team midwifery on Datix, concerns/complaints writing and report writing.
- Informed Corporate Governance of concerns and meet regularly to ensure collaborative working.

Recommendations

- Embed a MDT approach to governance (completed)
- Initiate weekly reviews of all datix with senior midwives and Governance lead (actioned)
- Close liaison with Corporate Governance
- All practice concerns to be agreed by MDT and in association with HR business partner (actioned)
- Fresh eyes review at Governance meeting
- Monthly newsletter with updates on themes and trends
- One action log for evidence of lessons learned
- Appoint Womens experience Midwife
- Lessons learned via table top reviews, safety huddles, MDT handover and training. (actioned)
- Exception report to COO to offer assurance and feedback regarding reporting, investigations and action log.
- Band 7s to report, investigate and feedback no and low harm events.
- An assessment to be completed to consider further action to include consideration to investigate and appropriate measures to ensure registrants understand roles and responsibilities. This may include professional bodies.

MBRRACE / Each Baby Counts 2017 Compliance Report

S Situation	The Directorate and Health Board requires assurance that all cases which meet the criteria for reporting to MBRRACE and Every Baby Counts data bases for 2017 (January – December) have been reported and that all data fields have been completed in full. Consequently the Head of Midwifery requested a review of the completeness of the Stillbirth, Neonatal Deaths and Late Fetal losses (22-23+ weeks) of the 2017 MBRRACE case reports due for submission end of September 2018. The review was undertaken throughout July and August 2018.
B Background	**Database Requirements:** **MBRRACE** 1. MBBRACE data entry for all Stillbirths, Neonatal Deaths and Late Fetal Loss for January – December 2017 cases need to be entered onto the MBRRACE database by 30th September 2018. 2. MBBRACE will send case report to Health Board in October 2018 to allow a final chance to check data completeness. 3. MBRRACE generates a list for each baby counts but recommend that this is not used in isolation to report to each baby counts. **Each Baby Counts (RCOG)** 4. Each Baby Counts has confirmed that although they prefer their database to be completed in a timely manner they confirm deadline for data entry for 2017 cases is March 2019.

A Assessment

Assessment:

Summary of Review

A total of 35 cases met the criteria for reporting to MBRRACE for 2017
One case of Late Fetal Loss (23 weeks gestation) was omitted as records were not available to the reviewer.

CTUHB reported cases to MBRRACE for 2016 and 2017

	2016	**2017**
Stillbirths	22	22
Neonatal Deaths	3	7
Late Fetal Loss (22-23+ weeks gestation)	NIL	5
Records not available		1*
Total reported	**25**	**34**

One case of Late Fetal Loss not reported to MBRRACE due to records being unavailable

Limitation of Review

To be completed week beginning 1 /10/18

Methodology

To ensure all cases of Stillbirths, Neonatal Deaths and Late Fetal Loss (22-23+ weeks gestation) for January to December 2017, have been included to inform the MBRRACE and Each Baby Counts databases, information was extracted/sort from the following:-

- Risk managers MBRRACE 2017 records
- Maternity Information Technology System (MITS)
- Badgernet (Neonatal Clinical System)
- Register of Miscarriages (Royal Glamorgan Hospital & Prince Charles Hospital)
- Bereavement officer database
- Audit department

Maternity Information Technology System (MITS)
Code: SB – Stillbirth, NND – Neonatal Death

Year		RGH NND	PCH SB	PCH NND	Home Other SB	Home Other NND	All SB	All NND	Total 2017
2017	13	2	6	0	3	1	22	3	25

Badgernet
Total 5 cases NND (1 baby of twin pregnancy, 2 babies of twin pregnancy)

Bereavement officer database
All cases included in original MBRRACE report.

Miscarriages Register Royal Glamorgan Hospital
Checked all cases already captured by Bereavement officer

Miscarriages Register Prince Charles Hospital
No register used in PCH
Report collated by Bereavement office and included above

Outcome of Review

CTUHB reported cases	2017
Stillbirth	**22**
Neonatal death	**7**
Late fetal Loss (22-23+ weeks gestation)	**5**
Total MBRRACE reportable	**35**
Case unreportable Late Fetal Loss no records available*	1*
Total cases reported MBRRACE 2017	**34**

Maternity records do not hold 2017 information no 2nd volume identified by Myrddin, therefore unable to be used to report LFL on MBRRACE 2017 report

CTUHB MBRRACE reportable cases for 2017	35
Total completed on MBRRACE	**34**
Outstanding case: Late Fetal Loss (records not available)	1
Cases notified and closed and completed accurately by the risk manager, with no update required.	**21**
Cases risk manager notified but required update by reviewer: including merger of 2 open reports for same case, antenatal data, missing fields	**4**
Cases risk manager notified and reviewer updated forename (middle name used) and number of sections and closed	1
Cases reviewer started and completed 5 Late Fetal Losses and 3 Stillbirths	**8**

Total assigned to CTUHB from another health board and Reviewer returned cases	**2**
Total assigned to another HB by Reviewer	**1**
Local multi-disciplinary review undertaken documented in MBRRACE by Risk Manager	14
Cases where NO documented/evidence Multi-disciplinary review undertaken: **Stillbirths = 10** (including cases: 4 feticide/congenital abnormalities, 1 unbooked pregnancy /congenital abnormalities, 1 unbooked pregnancy at home born before arrival) **Neonatal Deaths = 5** (including:1 cot death at home, 1 unbooked pregnancy at home born before arrival) **Late fetal Loss = 5**	20

Summary of findings:
Of the 34 cases reportable to MBRRACE 2017, 26/34 where notified by the risk manager. Of the 26 reported cases 21 where notified and closed by the risk manager and on review were completed accurately with no update required.

For the remaining 5 cases notified by the risk manager: 4 were updated by the reviewer and for one case the risk manager notified the case and the reviewer completed and closed the case.

A total of 8 remaining cases had not been notified to MBRRACE at the time of review. For these 8 outstanding cases the reviewer notified, completed and closed the MBRRACE reports. These 8 cases included 5 Late Fetal Losses and 3 Stillbirths.

Of the cases notified by the risk manager 14 cases included local multi-disciplinary review undertaken.

To be completed week beginning 1 /10/18

Deep Dive 2
Undertaken by Senior Midwifery Management Team on 1st August 2018 to review cases identified during the review of 2017 Stillbirths, Neonatal Deaths. Under the direction of the Head of Midwifery cases of: Late Fetal Loss, Feticide/Stillbirth, Congenital Abnormalities, SUDI/Cot Death were not included in the Deep Dive 2 exercise.

Outcome of Deep Dive 2:	
Number of cases met criteria for inclusion	**24**
Number of records available for review	**18**
Number of records **NOT** available at time of review	**6**
Number of records reviewed in Deep Dive 2 – fresh eyes	**18**
Number of cases identified as requiring a further Multi-disciplinary review	**2***
Of the 2 cases which underwent a multi-disciplinary review following Deep Dive 2, number of cases requiring a Serious Incident report	**2***

Please note same 2 cases

R **Recommendation**	**Recommendations:** • Develop a Stillbirth, Neonatal Death, Late Fetal Loss (22-23+ weeks gestation) excel database to include all relevant fields required for MBRRACE and Each Baby Counts reports. • Develop a robust process for reporting of all Stillbirths, Neonatal Death's and Late Fetal Losses (22-23+ weeks) on MBRRACE database in a timely manner. • Monitor compliance for completing Datix reports for all Stillbirths and Neonatal Deaths. • Review/renew Miscarriage/Late Fetal Loss register for use across the Health Board. Register headings need to include fields required to complete MBRRACE report. • Develop and maintain a robust process for completing Miscarriage/Late Fetal Loss register. • Develop and maintain a robust process for assessing cases that require a multi-disciplinary review. • Develop and maintain a robust process for planning multi-disciplinary review of cases. • Develop and maintain a robust process to evidence completion of multi-disciplinary review of cases. • Develop and maintain a robust process to update maternity and MBRRACE databases on results of Histology, post mortem etc.to ensure completeness of reports. • Audit completion of MBRRACE 2018 report in line with the recommendations of this review. • Missing questions in All Wales Maternity Records to facilitate completion of all required data fields of MBRRACE report: ➢ Raise awareness with community, antenatal clinic and acute midwives that whilst there is strong evidence of discussion with women on influenza vaccination in pregnancy there is a requirement to document date vaccination administered in the All Wales Maternity Records. ➢ Inform Head of Midwifery of data fields not available in All Wales Maternity Record that are required to be completed by MBRRACE i.e. Country of birth, time resident in UK, age at leaving school, woman's qualification attainment level, electronic cigarette use, documented influenza vaccination including date. ➢ Agreement of any additional data to be collected to be agreed by Heads of Midwifery Group and included in next updated version of All Wales Records.

Report completed by: Julie Evans – Senior Midwife
Date – 18th September 2018

Cwm Taf University Board Kirkup Action Group

Action plan following the Kirkup report (DRAFT v2)

Date developed	22 May 2015
Meeting date	21 September 2015
Monitored by	Cwm Taf University Health Board Kirkcup action group **Attendees** Rachel Fielding, Jonathan Pembridge, Lynne Millar Jones ,Myfanwy Ellis, Zoe Ashman, Meryl Wiltshire, Julie Evans, Sean Watermeyer.
Latest update	**21 September 2015**
Risk rating	No high risks identfied

Action taken

Cwm Taf University Health Board has:

- carefully considered all the recommendations of the Kirkcup Review
- reviewed it's position against all of the recommendations
- developed an action plan to strengthen areas of weakness identified through the review process
- assessed the risks to CTUHB of all these actions and prioritise high risk areas for immediate action
- has mapped it's improvement actions to the following themes:

Health Board action

1. Culture recommendation numbers – 1
2. Skills & Training - recommendation numbers – 2, 3, 4, 8, 14
3. Multi-professional working- recommendation numbers – 5,9,10,
4. Clinical Governance - recommendation numbers – 6,7,15,
5. Incidents & investigations- recommendation numbers – 11,12,13
6. Roles & Responsibilities - recommendation numbers – 16

Wider NHS action

Culture recommendation numbers –
Skills & Training - recommendation numbers – 4
Multi-professional working- recommendation numbers – 19, 23, 26,
Clinical Governance - recommendation numbers – 10,11,15,17,18,20,21,22,24,25
Incidents & investigations- recommendation numbers – 5, 6, and 7,9,12,13,14,16.
Roles & Responsibilities - recommendation numbers – 1, 2, 3

- will monitor progress through to completion

Theme : **Culture**						
Recommendation 1: The Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected. Green risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services. - Clinical review - CTUHB `Being open` policy -`Putting things right` leaflet. - Root Cause Investigations. - Supervisory investigations. - Quality & Safety Committee - Claims scrutiny panel. Complaints scrutiny panel - Patients' story - Parents meeting with HOM or deputy sharing records with them. - Root Cause Analysis Investigation. - GNC / NMC paper on Candour / openness has now been published. Staff have been made aware of this publication. - A named lead Has been identified from the concerns team to work with the Directorates so the detail of responses is improved. - The labour ward and risk meetings provide a forum to monitor and provide assurance.	The Directorates will continue with the work identified. Continue with individual feedback for the monitoring and assurance of concerns. GNC / NMC paper on Candour / openness sent to Obstetricians via e mail with the rota. The Directorate will look to provide families copies of the concerns meetings. This will be provided by tape / CD. Duty of candour to be placed on the Quality & Safety agenda. GMC / NMC draft paper. To date we await further update as to progress – HoM has sent e mail 12.06.15 to ask the position.	Monthly reports are provided which identify trends / themes. These are submitted to the Quality & Safety Committee. The 2 Directorates Quality & Safety Agenda is concerned with feedback concerning meetings with families / patients / RCA/ SoM reports / WRP reports / HIW visits and action plans. Supervisory Investigations are undertaken by external SoM. Reports are shared with the patient and family In an open and honest manner.	Directorate Quality & Patient Governance Group	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services.	In place April 2015	**21September 2015** This work is ongoing with multiprofessional engagement.

Theme: **Skills & training**						
Recommendation 2a: The Trust should Review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics, intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. Green risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate **Paediatrics / Neonatal Services** Professional Development Review Annual appraisals Supervisor of Midwife annual reviews. Annual validation / preparation Mandatory training ESR Self directed learning Supervisory reviews – 97% compliance. Welsh Risk Pool assessments RCOG EFM compliance Job Plans – SPA time given Professional Development Competency Framework Newborn Life Support Training European Paediatric Life Support Training Critical Care Scenario Training Qualification in Speciality	Prepare for re-validation by increasing staff awareness of re-validation by - Emails from Managers and Supervisor of Midwife. Ensure these remains an agenda item in team meetings. At induction midwife / nurses receive training which involves other services. Doctors. Ensure compliance through annual appraisals for revalidation.	Annual Supervisory reviews and PDR. Audits of compliance Training programme – Neonatal / Midwifery, Nursing & Obstetrics training programmes. Training records – all professions. Post grad and midwifery / nursing training database. Emails from Managers and SoM Agenda item in team meetings Individual job plans – all professionals have a responsibility to ensure they are updated to achieve competency. Audits of training e.g. CTG update.	Quality & Patient Governance Group	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	30 June 2016	**21September 2015** Clear training needs for obstetricians have been developed.

		Doctors Obstetric training sheets outlining minimum training Attendance sheets for paediatricians at individual resuscitation training for babies / children. Electronic portfolio for medics. Paediatric and Neonatal scenarios.				

Recommendation 2b: Identify requirements for additional training, development and, where necessary, a period of experience elsewhere. Green risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate **Paediatrics / Neonatal Services** Flexible integrated workforce. Cross site working Shadow working. Professional development reviews. ARCP. Is this correct??? What does this stand for?? PDR Lessons learnt from Concerns, incidents Any Additional Training is identfied through these meetings and is put into place.	Continue with the work as identfied in 2a. Close working in line with the South Wales Alliance (SWA).	There is workforce planning and work ongoing working with other Health Boards in relation to staff recruitment. There is evidence of midwives being given the opportunity to work across 2 HB`s. Health Board is engaged with the South Wales Alliance programme (SWA) Cross site working – Supervision – LSA Practice Programme Neonatal unit cross site working as part of the part 2 Neonatal Module. Cross site working – SoM and Senior Clinical Midwife <u>Doctors – ARCP.</u>	Quality & Patient Governance Group	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	30 June 2016	**<u>21 September 2015</u>** All staff are given the opportunity to have additional training and development when this has been identfied in other services or in other Health Boards.

Recommendation 3: • 3a The Trust should draw up plans to deliver the training and development of staff of maternity, neonatal and other staff • 3b. Should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice Medium risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
3a Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services Explore the possibility of having dual contract CTUHB & Cardiff & Vale. Joint Midwifery Interviews with Cardiff HB & CTUHB Secondments available for all staff Trainees and staff work cross site. The doctor and midwifery / nursing rotas identify cross site working. Mandatory monthly training Monthly multiprofessional training (PROMPT) Use of OD and HR in the training and development of staff. To ensure the continuing close working with the University of SW to deliver training. Qualification in speciality requires to staff to work in a Tertiary Unit. NN consultant visits CTUHB NNU once a month to share	To continue with the work in progress. To continue to work closely with the SWA To ensure there is annual update of the all educational programmes. To ensure the obstetric training sheets are distributed to all doctors and they are updated.	MultiProfessional training programme. Training records and database. Evaluation forms of the training programmes. Midwifery , nursing, obstetric & paediatric training records Staff induction training PDR Annual appraisals SoM reviews.	Directorate Quality & Patient Safety meeting Neonatal Network meetings LSA. ESR NMC Health Care Standards WRP	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	30 June 2016	**21 September 2015** Monitoring of Obstetric training has been improved.

practices and offer his experiences and expertise. Ensure a 6 month report is provided to the NN network. This ensures monitoring of compliance with the training.						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
3b. Should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice						
3b Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services Cross site working Supervisory reviews – Flexible integrated workforce. Cross site working Shadow working. Professional development reviews. ARCP. Is this correct??? What does this stand for?? PDR Lessons learnt from Concerns, incidents Dual contract CTUHB & Cardiff & Vale Qualification in speciality requires to staff to work in a Tertiary Unit.	Continue with the work as identfied in 2a. Close working in line with the South Wales Alliance (SWA).	There are opportunities for all staff to shadowing professionals. Medical trainees are able to have secondments. There is workforce planning and work ongoing working with other Health Boards in relation to staff recruitment. Health Board is engaged with the South Wales Alliance programme (SWA) Cross site working – Supervision – LSA Practice Programme Neonatal unit cross site	Directorate Quality & Patient Safety meeting	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	30 June 2016	**21 September 2015**. Staff are given every opportunity to broaden their experience when identfied.

		working as part of the part 2 Neonatal Module. Cross site working SoM & SCM				

Recommendation 4: Following completion of additional training / experience, the Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate **Paediatrics / Neonatal Services** Nurse / midwife re- validation pending Consultant re- validation in place**.** Supervisory reviews SCM / AMP ongoing work surrounding roles and assurance of safety - competencies at Induction. MSW / HSW training. Nurse re- validation All Wales Neonatal Standards There is ongoing work surrounding roles and assurance of safety - competencies at Induction.	To continue with the work in relation to AMP / SCM competencies. Establish 2015 / 2016 education programme which meets the need of the WRP standards	Training programme Training records and database Audit compliance with training needs. Audit programme to monitor progress. Staff induction training PDR Annual appraisals SoM reviews. HB has doctors database which monitors compliance with doctor's annual appraisals.	Directorate Quality & Patient Safety meeting	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	Sept 2016	**21 September 2015** The progress in this area is positive.

Recommendation 8: The Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity should be sought. Medium risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services Birth Rate + Compliant Senior management leadership for SW plan NICE safe staffing standards in Maternity – HOM undertaking a piece of work to compare NICE & BirthRate Plus. Support worker training Advanced midwife / nurse roles. Joint posts linking with the university – Training Undergraduate Link midwife for medical students. Band 7 development programme. HB flexible working programme. Recruitment to the SW Alliance Programme. Neonatal Capacity Review Senior management leadership for SW plan All Wales Neonatal Standards Training for staff	To progress the bid for Consultant Midwife for Normal Birth Continue to develop Specialist Roles in Midwifery & Nursing. Embed the skills passport which the University has in place. Support the Newly Qualified Midwife Induction Process Facilitate training for the maternity staff – neonatal drug administration / NG tube feeding. Identify the need for Paediatric recruitment in the Acute & Community areas to ensure safe working. To continue to work to the Intermediate Medium Term Plan – 3 year plan.	Job profiles Birth Rate + Compliant Audit programme / results. Training records and database. Paediatric NN Intermediate and Long term plan to recruit paediatricians in readiness for the SW programme.	Directorate Quality & Patient Safety meeting	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	January 2016	**21 September 2015** This is work in progress.

Recommendation 14a: The Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate **Paediatrics / Neonatal Services** Leadership – medical and nursing / midwifery forums in place. Job descriptions – clear roles and responsibilities. New SoM structure Band 7 development days Band 6 development days - Acute & Community setting Preceptorship programme Management leadership programmes for Senior Managers. Monthly medical leadership forums – Forum for CD. This allows CD the opportunities to shadow HR links within the organisation with the Directorate and individuals. Clinical Business Meeting Directorate Meetings Leadership modules – RCN/ RCM Midwifery only – News SoM model. PACT leadership programmes. Academy of Wales Leadership programmes.	To ensure there is clear clarity surrounding ob profiles / description to ensure there is no blurring of different roles / responsibilities All Wales HoM to develop a programme for development for the 8a role.	Various Job descriptions Individual Job plans Training days Training programmes and database.	Directorate Quality & Patient Safety meeting LSA	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	30 June 2016	**21 September 2015** This is in place

Recommendation 14b: All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate **Paediatrics / Neonatal Services** Leadership – medical and nursing / midwifery forums in place. Band 7 development days Band 6 development days - Acute & Community setting Preceptorship programme. National & Local Management leadership programmes for staff / Senior Managers. Monthly medical leadership forums – Forum for CD. This allows CD the opportunities to shadow. HR links within the organisation with the Directorate and individuals. Clinical Business Meeting. Directorate Meetings Leadership modules – RCN RCM Academy programme available. PDR Revalidation ESR Midwifery only – New SoM model. Supervisory reviews	To ensure there is ongoing education programmes in place to reflect the professional needs. Ensure up to date training records are maintained. To ensure staff continue to be open and honest to patient and families.	Training days Training programmes Audit programme / audit records. Training records and database of attendance.	Directorate Quality & Patient Safety meeting	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	Sept 2016	**21 September 2015** This is in place.

Theme 3: **Multi-professional working**						
Recommendation 5: The Trust should Identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of Employment. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate **Paediatrics / Neonatal Services** **To ensure the following forums continue and develop:** Prompt, and mandatory training Obstetric Drills Induction training – fire, V&A,Manual Handing Neonatal communication proformas are completed MultiProfessional Handovers WHO Checklists are maintained Perinatal mortality meetings MultiProfessional working groups which develop action – high risk folder. Completed audit and presentation of the audit findings. Secure the Audit & Guideline midwife position MSLC group Guideline meeting to review and develop policies / guidelines. SoM record keeping tea party Labour ward forum Safety briefing	CD of obstetric to explore the possibility of joint consultant meetings on a 2 monthly basis to improve communication and joint working. The Senior Midwife team and DM team to also attend. The DM team to arrange that clinicians are able cancel commitments once a month to ensure their attendance at the Q&S / consultant meetings To establish a midwife labour ward co ordinator on both labour wards. She will co ordinate multidisciplinary team working To explore the possibility of a joint labour ward forum every 2 months To ensure the postion of the Audit & Guideline midwife post –	Annual audit programme Job descriptions Audits database. Risk register Education training programmes for – midwifery, obstetrics, nursing & paediatrics. PROMPT Training records and database Notes of meetings to demonstrate multiprofessional working Action plan following audit meetings Handover sheets. Safety briefings.	Directorate Quality & Patient Safety meeting	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	30 June 2016	**21 September 2015.** It is hoped the commitment to cancel clinical commitments will be in place by December 2015.

Annual Mortality meetings Joint O& G/ CYP meetings. Critical Care scenario training Audit programme Perinatal mortality meetings MultiProfessional working groups which develop action – high risk folder. Neonatal communication proforma Joint O& G/ CYP meetings Induction training for all new staff. Quality & Safety forums Labour ward forums To develop Joint consultant meetings.	secondment or permanent position. To promote links with other professionals to ensure joint working To improve the audit process so there is an audit programme which reflects service and patient needs. To agree an annual audit programme which is mirrored on both sites? All audits to be registered with the audit department Audit results to be shared with staff Lessons learnt to be shared and actions implemented to improve patient safety and improve standards. To ensure the HB executive board is made aware through exception reports and meetings of Induction training – fire, V&A,Manual Handing The risk associated with lack of manual handling / V&A training for all staff.	Postnatal mortality / morbidity meetings – agenda and minutes,				

	To explore joint working with Paediatric. Neonatal/ Obstetricians with regards to training.					

Recommendation 9: The Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. It was not identfied that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling; we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate **Paediatrics / Neonatal Services** **To ensure the following forums continue and develop:** Joint site working. All professionals informed working across both sites Written in every CT contract to work anywhere in the health board where service requires Inter site bus Joint guidelines between the sister sites. HR policies are organisational	Explore the possibility of having Video conference facilities if professionals are not able to attend Directorate meetings in person. CD of obstetric to explore the possibility of joint consultant meetings on a 2 monthly basis to improve communication and joint working. The Senior Midwife team and DM team to also attend. This will reduce travelling time to attend meetings. The DM team to arrange that clinicians are able cancel commitments once a month to ensure their attendance at the Q&S / consultant meetings To establish a midwife labour ward co ordinator on both labour wards.	The Directorates guidelines cover both sites and are available in Sharepoint for all staff to access. HB policies, procedures are available for staff to access on Sharepoint. There are notes of minutes where guidelines are reviewed and notes of the Quality & Safety meeting where guidelines are ratified. Some clinical job roles are site specific e.g. Labour ward co ordinator/ ward managers. Senior Midwife / Nurse r job roles cover both sites. Job Descriptions	Directorate Quality & Patient Safety meeting	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	Sept 2016	**21 September 2015** This work is ongoing.

	To explore the possibility of a joint labour ward forum every 2 months To promote links with other professionals to ensure joint working Lessons learnt to be shared and actions implemented to improve patient safety and improve standards. To ensure the HB executive board is made aware through exception reports and meetings of Induction training – fire, V&A,Manual Handing The risk associated with lack of manual handling / V&A training for all staff. To explore joint working with Paediatric. Neonatal/ Obstetricians with regards to training.					

Recommendation 10: The Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as 'buddying'. This could involve the same centre identified as part of the recruitment and retention strategy. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate **Paediatrics / Neonatal Services** **To ensure the following forums continue and develop:** Cross site working Supervisory reviews The SWA programme will improve links with partner Trusts. Staff are encouraged to work between Neighbouring Health Boards. Staff are encouraged to have buddy or coaches from other Health Boards. e.g. Supervisor of Midwife There is CTUHB representation on National forums such as the All Wales Maternity Network – 100 Lives. There are opportunities for staff to have secondments within the Directorates	Continue to work with neighbouring hospitals as part of the SWA Inform staff of the South Wales Alliance programme - updates and progress. Continue with All Wales work – Maternity Network Wales.	SWA programme minutes and action plans. Job descriptions Midwives / nurses working from other Health Boards. Notes of various forums e.g. Maternity Network meetings. The paediatric Junior doctors rota show they rotate between different Health Boards. – SARC. Notes from the All Wales Head of Midwife meeting indicate shared learning. Notes from the Senior Nurse forum indicate shared learning.	Directorate Quality & Patient Safety meeting	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	**September 2016**	**21 September 2015** The Directorates make every effort to forge links with other Health Boards to ensure learning, mentoring, and secondment for staff development.

Theme 4 : **Clinical Governance**						
Recommendation 6: The Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: • 6a who should be offered the option of delivery low risk units and who should not. • 6b who will carry out this assessment against which criteria. • 6c how this will be discussed with pregnant women and families. • 6d the protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. • 6e. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff is aware that They should not vary decisions without a documented risk assessment. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
6a. Who should be offered the option of delivery low risk units and who should not? **Obstetrics / Midwifery & Sexual Health Directorate** **Paediatrics / Neonatal Services** To ensure midwifery led forums continue and develop All Wales MLC Guidelines Audit programme to monitor compliance. Birth Choice Clinic and leaflets MLC transfer meetings Job description for a Consultant Midwife Normal labour pathway Risk Assessment forms at booking.	Drive forward the Consultant Midwife Post for Normal birth. This will ensure there is discussion with GP and stakeholders Continue to ensure staff are aware of the need to provide appropriate care to individual women based on individual needs and risks	Job description Hand held notes Birth choice polices / leaflets Birth choice clinics arrangements Audit programme and audit results Individual birth plans Action plans All Wales Birth Centre Guidelines Minutes of meetings	Directorate Quality & Patient Safety meeting	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	30 June 2016	**21 September 2015** This work is ongoing.

Position	Action needed	Evidence	Monitoring Arrangements	By who	Completion date	Update/ progress
6b Who will carry out this assessment against which criteria **Obstetrics / Midwifery & Sexual Health Directorate** **Paediatrics / Neonatal Services** To ensure midwifery led forums continue and develop TABC midwifery team 24 / 7. All Wales MLC Guidelines Audit programme Birth Choice Clinic and leaflets MLC transfer meetings Job description for a Consultant Midwife Normal labour pathway	Drive forward the Consultant Midwife Post for Normal birth. This will ensure there is discussion with GP and stakeholders	Job description Birth choice polices / leaflets Audit results relating to this. Monthly obstetric / midwifery statistics. Maternity Dashboard. TABC transfer meetings. Midwifery led guidelines Minutes of Midwifery led team meetings	Directorate Quality & Patient Safety meeting Welsh Risk Pool	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	30 June 2016	**21 September 2015** This is ongoing.

Position	Action needed	Evidence	Monitoring Arrangements	By who	Completion date	Update/ progress
6c How this will be discussed with pregnant women and families **Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services** Documented in hand held notes/ANC All Wales Birth Centre Guidelines TABC midwifery team 24 / 7 Midwifery led audits and audit programme Birth Choice Clinic and leaflets MLC transfer meetings Job description for a Consultant Midwife Normal labour pathway MSLC meetings – user presence User audit and walkabout Maternity Network user forum - established September 2015.	Drive forward the Consultant Midwife Post for Normal birth. This will ensure there is discussion with GP and stakeholders Continue to drive the normal birth agenda	Job description Birth choice polices / leaflets Audit results All Wales Birth Centre Guidelines Minutes of meetings Monthly obstetric / midwifery statistics TABC statistics TABC transfer meetings MSCL meetings Maternity network user presence Study days for professionals in relation to Normal Birth MultiProfessional training Protocols / guidelines available on the HB Sharepoint	Directorate Quality & Patient Safety meeting	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	30 June 2016	**21 September 2015** This work is ongoing.

Position	Action needed	Evidence	Monitoring Arrangements	By who	Completion date	Update/ progress
6d. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region **Obstetrics / Midwifery & Sexual Health Directorate** **Paediatrics / Neonatal Services** All Wales MLC Guidelines Staff groups giving care is documented in hand held notes/ANC This is discussed in TABC midwifery team meetings Midwife led care is provided 24/7 Audit programme involves midwife practise Birth Choice Clinic and leaflets MLC transfer meetings	Drive forward the Consultant Midwife Post for Normal birth. This will ensure there is discussion with GP and stakeholders Continue to drive the normal birth agenda	Job description Birth choice polices / leaflets Audit Directorate guidelines and policies Minutes of meetings MSCL audit Maternity network user presence.	Directorate Quality & Patient Safety meeting	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	30 June 2015	**21 September 2015** The Consultant Midwife proposal has been submitted to the Exec team and there are ongoing talks with the University of South Wales to explore the possibility of a combined role.

Job description for a Consultant Midwife Normal labour pathway.						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
6e. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff is aware that They should not vary decisions without a documented risk assessment. Low risk						
Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services NLP All decisions and plan of care are documented in hand held notes/ANC There is an area in the hand held notes which allow women and their families to document their preferences and experiences TABC midwifery team 24 / 7 All Wales MLC Guidelines Audit programme includes monitoring of compliance Birth Choice Clinic and leaflets MLC transfer meetings Job description for a Consultant Midwife Normal labour pathway Clinical reviews Risk meetings Quality & Safety meeting Quality & Safety Assurance Reports Maternity dashboard	To continue to take forward woman centred care To complete the annual record keeping audit to ensure there is compliance with record keeping standards and other HB guidelines Audits to be completed to monitor adequate risk assessment of women	PDR Annual appraisal SoM annual review Maternity dashboard SBAR relating to the maternity dashboard Various reports and exception reports. Training records and programme Guidelines Annual record keeping audit Audit programme Audit meeting minutes and action plan.	Directorate Quality & Patient Safety meeting	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	30 June 2015	**21 September 2015** The annual audit programme has been reviewed to ensure this action is addressed.

Annual WRP assessment NMC standards NMC Code 2015.		Jump Call process				
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Recommendation 7: The Trust should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups. Low risk						
Obstetrics / Midwifery & Sexual Health Directorate **Paediatrics / Neonatal Services** Case note reviews Audit programme MLC transfer meetings Clinical review Risk meetings Quality & Safety meeting Assurance Reports Maternity dashboard WRP assessment on an annual basis monitors this All Wales inutero transfer form. Incident reporting RCA investigations Clinical review Risk meetings Quality & Safety meeting Assurance Reports Datix Incident reporting RCA investigations.	To take forward the Consultant Midwife Post for normal birth To agree an All Wales Maternity Dashboard The Senior Midwife for Community Services will complete an audit to identify whether the appropriate professional lead To contribute to the All Wales audit of the Inutero transfer form.	Maternity dashboard SBAR relating to the maternity dashboard which is sent to the Director of Nursing on a monthly basis Various reports and exception reports Training records and programme Guidelines Audit programmes and audit presentations and recommendations Clinical review RCA reports. All Wales Inutero transfer forms	Directorate Quality & Patient Safety meeting	Head of Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	Sept 2016	**21 September 2015** This work is ongoing

Recommendation 15: The Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services. It is recommended that a full audit of implementation be undertaken before this is signed off as completed. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services Health Board assurance framework for every Directorate Organisation governance audit Maternity Network Directorates Quality & Safety Directorate group meetings to provide assurance for Governance Exception reports from clinical areas The Directorates provide update and assurance at the Health Board Quality & Safety / Concerns Scrutiny panel The Directorate provide Annual Q&S annual report and presentation to the Organisation Neonatal Network Trigger tool audit	To continue to improve engagement between professionals to strengthen CG arrangements through improved attendance at Q&S forums. To explore VC facilities at the Q&S and other governance forums.	Minutes of Q &S meetings Q&S Exception reports Audit findings Patient stories / video Compliance with the Neonatal Standards Health & Care Standards	Directorate Quality & Patient Safety meeting	Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	Sept 2016	**21 September 2015** The Directorates considers there are good systems in place to provide the HB with assurance of high quality of care.

Recommendation 15: The Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite (at Furness General Hospital), including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services SWA planning meeting There is Joint working with the Obstetric & Paediatric Directorates in preparation for the New Obstetric Unit in PCH. MSLC audit and walkabout asking patient views Patient stories Concerns and user feedback Service development meetings Control of Infection audit Estate audit Skin audit Hygiene audit FOC audit Service development meetings Close liaison with the Surgical and anaesthetic Directorates	To continue to work in partnership with other Directorates and team to ensure high standards are in place in readiness for the new Obstetric unit in PCH. To continue user representation at the Directorate forum so their voice is heard.	Minutes of the Joint meetings Minutes from the User group meeting The obstetric plan and minutes. Audits of environmental Evaluation of care forms	Directorate Quality & Patient Safety meeting	Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	2016	**21 September 2015** The work for the New Obstetric Unit in PCH is ongoing.

Recommendation 18: All of the previous recommendations should be implemented with the involvement of Clinical Commissioning Groups, and where necessary, the Care Quality Commission and Monitor. In the particular circumstances surrounding the University Hospitals of Morecambe Bay NHS Foundation Trust, NHS England should oversee the process, provide the necessary support, and ensure that all parties remain committed to the outcome, through an agreed plan with the Care Quality Commission, Monitor and the Clinical Commissioning Groups.						
No action required for CTUHB		This needs to be addressed in the Welsh Government	Not applicable	Not applicable	**Not applicable**	
Theme 5: **Incidents & Investigations**						
Recommendation 11a: The Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate **Paediatrics / Neonatal Services** Datix reporting of incidents Trigger lists Mandatory in house training Risk and staff Newsletter Labour ward forums Band 7 meetings I-Care SoM involvement and review Band 7 feedback Lessons learnt newsletter Patient stories and videos. Staff involvement in the RCA process	To continue to raise awareness of incident reporting and informing of the benefits and processes.	Newsletters Datix forms. Evidence of obtaining staff views with regards to the RCA process – interviews. Minutes of meetings Incident form and reviews Action plans following Datix reviews Guidelines for staff Flowchart to support staff Open door policy to Senior staff Training programme which has a risk update session	Directorate Quality & Patient Safety meeting	Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	April 2016	21 September 2015 There are good processes in place to inform staff .

11b. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate **Paediatrics / Neonatal Services** CTUHB Being Open Policy CTUHB Concerns Policy Candour of care document Evaluation of care, electronic feedback re the service so concerns can be dealt with immediately and managed and recorded via FOC Supervisory reviews GNC / NMC rules / code/ standards LSA workshop planning information Rules for workshops on behaviour, standards and language	To continue with the present work	Health Board policies , standards and guidelines Audit programme which identifies compliance	Directorate Quality & Patient Safety meeting	Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	April 2016	**21 September 2015** This work is ongoing.

Recommendation 12a: The Trust should: review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate **Paediatrics / Neonatal Services** CTUHB policy Concerns Policy Band 7 involvements in support and debrief out of hours when clinical incident has happened. Staff views are taken into account in relation to the investigation process. Learning through workshops, debrief sessions, teaching and newsletters. There is an open door policy for staff to access the management team at any time Identified named link for the Directorates are now in place to provide support and advice Training programme has been reviewed to ensure this is included	To continue with the work and involve staff in RCA / SoM investigations.	Health Board policy Supporting staff flowchart RCA reports and action plans Trainig programme Face to face interviews are now in place for investigations. This is an action based on staff feedback.	Directorate Quality & Patient Safety meeting	Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	April 2016	**21 September 2015** Staff are involved in this process at al times

12b. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate **Paediatrics / Neonatal Services** Datix Incident reporting Clinical review Tabular timeline All staff are offered a debrief following an incidents or serious event Team debrief Individual debrief Band 7 debrief What happens when there is a clinical incident- this informs staff of the process of investigation, either HB or SoM Supervisory reviews Peer support Action plans developed following investigations Staff are able to self refer to staff health or be referred by the manager Directorate Psychology support.	To continue to improve and identify how staff can be supported and how Best to support staff. Encourage staff to contribute as to how managers can support staff in difficult times.	Flowchart – Supporting staff following traumatic event is in place. Date in the calendar E mails inviting staff to attend debrief sessions. Referrals to staff health if further support is needed.	Directorate Quality & Patient Safety meeting	Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	October 2015	**21 September 2015** The work is ongoing how we can continue to support staff. This is improved with close communication with staff.

Recommendation 13a: The Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services Awareness of the Duty of Candour document On the spot concern forms are available in the clinical areas for staff to complete. Listening and Learning to Improve Patient Experience' June 2015 is shared with staff which emphasises how important the Patient Experience is for us all. A claims / concerns co ordinator is in post; - to improve response times, - improve the concerns process - provide a contact for women and users of the service Staff identified as having been involved in the care are asked for their views / account of events so an open and honest response can be given.	To continue to be open and honest in our approach Collaboration with the concerns team in line with the 'gift of complaints' to engage staff in the complaints process.	Various staff newsletters Individual concerns responses Reports and action plans Directorate Exception reports Maternity dashboard which indicates the informal and formal concerns received on a monthly basis. E mails communicating to staff.	Directorate Quality & Patient Safety meeting PC&SU	Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics , Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	September 2015	**21 September 2015** This work continues to be ongoing in partnership with staff.

The final response letters are shared with staff. Lessons learnt are identified and action plans developed**.** Feedback of trends are given to staff via newsletter 1:1 meetings with individuals are arranged if necessary Monitoring of trends via the concerns team Final responses are approved by the Head of Midwifery / Nursing before they are sent to the concerns team or to the complainant. There is involvement with the service user so lessons can be learnt There is a named link allocated to the Directorate from the HB Concerns team. This improves communication and quality of the service. Notes of meetings are shared with the user. Directorate exception report are submitted to the Health Board to provide assurance of robust processes in place.						

13b. should increase public and patient involvement in resolving complaints, in the case of maternity services through the MSLC. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services Community Health Council visits and reports MSLC meeting which is held every quarter and the Chair of this meeting is a service user A update report is produced at every MSLC meeting in relation to concerns Individual feedback via risk newsletter 1:1 meeting with individual staff when a concern is received Capability commenced when necessary Monitoring of trends via the concerns co ordinator All reports and action plans are shared with patients and families when an investigation or review has been completed	To continue to be open and honest in our approach with staff and the patients Encourage a culture of open and honesty To encourage users to be involved in patient story	Notes of concern minutes Staff newsletter Concern responses and action plans Investigation reports Directorate exception reports which give the HB assurance of robust processes and user involvement. Maternity dashboard	Directorate Quality & Patient Safety meeting	Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics , Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	September 2015	**21 September 2015** The MSLC user representation is healthy.

The users are offered a copy of all action plans and reports when finalised An opportunity to meet with the family is offered. The Supervisor of Midwife is involved when necessary and visits to the home are offered There are good involvement and links with the concerns department						

Theme 6 : **Roles & Responsibilities**						
Recommendation 16: As part of the governance systems work, the Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services This is an organisational-wide responsibility. Individual responsibilities regarding their roles Job descriptions Personal development reviews Annual Supervisory reviews Leadership forums Organisational development days 1:1 weekly meeting with the Head of Midwifery / Nursing.	To offer 8a managers leadership courses To try to implement joint meetings to ensure all professionals have an understanding of others roles and responsibilities	Job descriptions Personal development reviews Annual Supervisory Reviews	Directorate Quality & Patient Safety meeting	Director of Midwifery / Nursing Medical Director Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	Dec 2015	**21 September 2015-** The Directorate and organisation continue to support the staff in this

Recommendations for the wider NHS Many of these recommendations are for other Health Boards The bodies responsible for leading and ensuring that action is completed has been identified.						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Theme : **Roles & Responsibilities**						
Recommendation 1: In light of the evidence in the Investigation report the **professional regulatory bodies** should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation.						
Obstetrics Wait for recommendations from professional bodies such as RCM.	https://www.rcog.org.uk/en/news/rcog-response-to-the-kirkup-report/  RCM RESPONSE					
Recommendation 2: There should be a **national review** of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them.						
Obstetrics Welsh Government & HoM's – plan to review maternity services. **Paediatrics** Wait for action from the Neonatal Network report relating to the SW programme.	Review programme – Key points will be identfied through WG in 2015 for the short term, medium term and long term priorities.					

Recommendation 3: The challenge of providing healthcare in areas that are rural, difficult to recruit to or isolated is not restricted to maternity care and paediatrics. We recommend that NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments.						
National government action						
Theme : **Skills/ training**						
Recommendation 4: We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services There are rotational posts between the HB and other neighbouring Health Boards. Shadowing opportunities within the organisation for all levels of staff There are secondment opportunities within and outside the Directorate. Staff are also supported to apply for secondments outside the Organisation. Shared working with Cardiff & Vale in recruitment Training programmes demonstrate good links with other larger units-	To continue to support staff and links with larger units and also on an all Wales basis.	Secondment job profiles. Training programmes. E mails supporting links and communication**.**	Directorate Quality & Patient Safety meeting	Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	September 2015	**21 September 2015** There are good links with larger neighbouring Health Boards

Links on an All Wales Basis – All Wales HoM Network, Maternity Network						
Theme: **Incidents/ Investigation**						
Recommendation 5: Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. There is a strong case to include a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review, and should certainly be framed to exclude conflicts of interest between staff. Recommend that this build on national work already begun on how such a process would work. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services Datix Incident reporting. CTUHB Incident reporting policy. Directorate and Organisation trigger lists. Maternity Standards report to Welsh Government. Root Cause Analysis Investigation. HR investigation. Supervisor of Midwife links. Supervisor of Midwife review and investigation. – These are	To continue to work closely with the patient safety team. .	Investigation reports and action plans. Organisation protocols and policies relating to concerns Individual interviews and statements from staff Directorate exception reports	Local monitoring Directorate Quality & Patient Safety meeting.	Patient care and Safety Unit	In place	**21 September 2015** This work is ongoing.

undertaking by an external SoM. MBRRACE. Every Baby Counts. All families are informed of investigations. The reports and action plans are shared with the parents and family. Multidisciplinary workshops. Perinatal mortality meeting. Putting Things Right in place Directorate exception reports Newsletters Serious incident reporting to the Welsh Government.						

Recommendation 6: We commend the introduction of the **duty of candour** for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services Putting Things Right in place Openness and honesty when things go wrong: the professional duty of candour NMC / GMC. .Datix Incident reporting. CTUHB Incident reporting policy. Directorate and Organisational trigger lists. Standards report to Welsh Government. Root Cause Analysis Investigation. HR investigation. Supervisor of Midwife links. Supervisor of Midwife	To continue to ensure all professionals work to high standards in partnership with the woman and her family. To continue to heighten staff awareness	Notes of meetings Investigation reports and action plans NMC code Midwives rues Supervisor of midwives standards 'Listening and Learning to Improve Patient Experience' report Duty of candour document	**Local monitoring** Directorate Quality & Patient Safety meeting.	Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	In place May 2015	**21 September 2015** This is ongoing work

investigation reports. – These are undertaking by an external SoM. MBRRACE. Every Baby Counts. All families are informed of investigations The reports and action plans are shared with the parents and family. Multidisciplinary workshops. Perinatal mortality meeting.						

Recommendation 7: We recommend that a duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality Commission should develop a system to disseminate learning from investigations to other Trusts.						
No action required for CTUHB		**Welsh Government Action.**	**Welsh Government Action**	**Welsh Government Action**		
Recommendation 9: Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse from professional standards.						
This is a Professional Regulatory body action.						
Recommendation 12: A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation.						
No action required for CTUHB		**Welsh Government**		**Welsh Government Action**		**Welsh Government Action**
Recommendation 13: The NHS complaints system in the Trust failed relatives at almost every turn. Although it was not within the remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints.						
No action required for CTUHB Evans Review Gift of Complaints recommendations require implementation			Directorate Quality & Patient Safety meeting			

Recommendation 14: The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the Trust, not only in individual failures of care but also with the systems to investigate them. It was not within the report remit to examine the operation of the system nationally; however, the nature of the failures and the recent King's Fund review (*Midwifery regulation in the United Kingdom*) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King's Fund findings, with effective reform of the system.						
Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services. Model for Future Proofing of Supervision in Wales. No action required by CTUHB.						
Recommendation 16: The relationship between the investigation of individual complaints and the investigation of the systemic problems that they exemplify gave cause for concern, in particular the breakdown in communication between the Care Quality Commission and the Parliamentary and Health Service Ombudsman over necessary action and follow-up. We recommend that a memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap.						
Action for the Regulatory bodies.						

Theme: **Culture**						
Recommendation 8: We commend the introduction of a clear national policy on whistle blowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified. Low risk						
No action required – local policy in place		**Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services** The Health Board Whistle Blowing Policy is in place	Directorate Quality & Patient Safety meeting		May 2015	21 September 2015 Work is ongoing.

Theme: **Clinical Governance**						
Recommendation 10: Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met.						
Welsh Government Action		Welsh Government Action	Welsh Government Action	Welsh Government Action		Welsh Government Action
Recommendation 11: Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met.						
Welsh Government Action						
Recommendation 15: The report considered carefully the effectiveness of separating organisationally the regulation of quality by the Care Quality Commission from the regulation of finance and performance given the close inter-relationship between Trust decisions in each area. However, the investigators were persuaded that there is more to be gained than lost by keeping regulation separated in this way, not least that decisions on safety are not perceived to be biased by their financial implications. The close links, however, require a carefully coordinated approach, and the recommendations are that the organisations draw up a memorandum of understanding specifying roles, relationships and communication.						
No action required for CTUHB Action for Regulatory Bodies						
Recommendation 17: A protocol to be developed that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility.						
Action for Regulatory Bodies						
Recommendation 18: The cumulative impact of new policies and processes, places significant pressure on the management capacity of the Trusts to deliver against changing requirements whilst maintaining day-to-day needs, including safeguarding patient safety. Recommend that the **Department of Health** should **review how it carries out impact assessments** of new policies to identify the risks as well as the resources and time required.						
National Government action						

Recommendation 20: Recommend that mortality recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services. MBRRACE Welsh Initiative Stillbirth Reduction. Every Baby Counts Perinatal mortality meetings. Neonatal network	To continue to maintain robust reporting**.** To continue to promote multiprofessional working to review deaths and incidents	MBRRACE reports Every baby count reports Neonatal death reviews	Directorate Quality & Patient Safety meeting	Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	June 2015	**21 September 2015**

Recommendation 21: To ensure there is a mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. The systems should be based on medical examiners, as it has proved to be effective in other countries and pilot schemes. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services. MBRRACE WISR Every Baby Counts Peri natal mortality review Peri natal mortality review	To continue to promote multiprofessional working to review deaths and incidents	MBRRACE reports Every baby Count reviews Perinatal reviews and reports. Mortality reviews.	Directorate Quality & Patient Safety meeting	Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services	June 2016	**21 September 2015** The Directorate continues to work to maintain patient safety

Recommendation 22: Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths; ensuring appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate **Paediatrics / Neonatal Services** MBRRACE WISR Every Baby Counts Peri natal morality review Mortality deaths Peri natal morality review	To explore whether the adult mortality review process can be extended to maternity.	MBRRACE reports Every baby Count reviews Perinatal reviews and reports. Mortality reviews.	Directorate Quality & Patient Safety meeting.	Midwifery, Paediatric & Neonatal Nursing / Clinical Director of Obstetrics, Gynaecology & Sexual Health Clinical Director of Paediatrics & Neonatal Services.	June 2016	**June 2015** This is in place and continues
Recommendation 24: We further recommend that all external reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts.						
Action for the Welsh Government						

Recommendation 25: Emphasis must be placed on the quality of NHS services as identified in many reports, during NHS reconfiguration which could result in new organisations and post-holders losing the focus on this. Recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations Medium risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services PACT programme for investment for clinical leaders.	Chief Executive is the organisational lead.		Directorate Quality & Patient Safety meeting			

Theme: **Roles & Responsibilities**						
Recommendation 19: Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. Recommend to develop an explicit protocol setting out how such processes will be managed in future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. Medium risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate Paediatrics / Neonatal Services HR policies	To improve HR engagement with the directorates		Directorate Quality & Patient Safety meeting	Senior managers	August 2015	21 September 2015 To obtain HR advice.
Recommendation 23: There was concern by the ad hoc nature and variable quality of the numerous external reviews of services. Recommendation that systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them.						
National Government action						

Recommendation 26: Recommend that there is an established framework in place covering matters such as access to documents, the duty of staff and former staff to cooperate, the legal basis for handling evidence. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current and former health service staff to cooperate. Low risk						
Position	**Action needed**	**Evidence**	**Monitoring Arrangements**	**By who**	**Completion date**	**Update/ progress**
Obstetrics / Midwifery & Sexual Health Directorate **Paediatrics / Neonatal Services** Organisational HR policies Medical records policies. Corporate polices & procedures. NMC code Concerns process SOM review and investigation Concern / claims co ordinator in post to assist this process. Notes Are scanned / photocopied when areas of concern have been highlighted.	Staff are updated in the risk session within the mandatory Obstetric / midwifery training day on governance issues. Ensure there is an effective framework in place which is understood by all employees.	Policies and procedures. NMC code.	Directorate Quality & Patient Safety meeting	PC&SU	June 2015	**21 September 2015** This work is ongoing.

Pulse Survey Report for Midwifery Services
(Part Two)

Deborah Porter
Senior Business Partner

22nd March 2017

1. Background of the Pulse Survey "What's Work Like For You"

1.1 In October and November 2016, some issues were raised by Maternity staff which needed to be resolved, and as some of these issues were raised anonymously they were difficult to investigate and resolve.

1.2 It was decided that the first stage in resolving these issues would be to take a pulse survey of Maternity staff which would help to establish the scope and range of issues that needed to be resolved.

2. Methodology

2.1 The Workforce & OD Department designed a questionnaire using Survey Monkey, with full co-operation from the Trade Unions. The survey opened on Friday 25th November, 2016, initially for two weeks, however it was extended until it closed on 6th January 2017. The survey was accessed via a link contained in emails sent directly to each member of staff.

2.2 Staff were assured that any member of staff, of any grade, could speak to the Head of Midwifery, Rachel Fielding, without fear for their position and in confidence, so that their concerns could be understood and investigated. Staff were also reminded that their trade union representatives were there to provide support.

2.3 Each member of staff would receive a copy of the Survey Report which would be available approximately four weeks after the survey closed.

3. Findings

3.1 A total of 82 staff responded to the survey, which from a total of 212 staff currently employed in the Directorate as a whole represents a 39% response rate.

3.2 The highest number of responses were from RGH Acute with 48.7%, followed by PCH Acute with 32.9% and Community/Birth Centre/Ante-Natal with 18.2%.

3.2 Response rates related to Bandings were the highest amongst Band 5/6 with 58.5%, followed by Band 7 with 21.9 % and Bands 2/3/4/ with a 19.5%response rate.

3.2 The complete findings set out in tables from Question One through to Question Twenty-five were sent out via email to all maternity staff on 20th January 2017.

4. Next Steps

4.1 It was agreed that a Maternity Voices Forum would be created and the inaugural meeting would take place in February 2017. The purpose of the Forum would be to improve communications within the Department, and to resolve the issues raised in the survey through the themes. The membership of the Forum would consist of:

- Head of Midwifery
- Nominated Senior Midwife
- Senior Business Partner, Workforce & OD
- HR Adviser for Maternity
- Nominated members of staff from PCH Acute, RGH Acute and Community/Birth Centre/Ante-natal with representative grades from Band 2/3/4 , Band 5/6 and Band 7 for each of those areas
- Trade Union Representatives from UNISON, RCN, UNITE and RCM

4.2 Further analysis of the findings would be undertaken by the Workforce & OD department, particularly regarding the free text questions:

Question 26 Please describe any concerns you may have

Question 27 Please describe any suggestions for improvement

Emergent themes would be identified, such as staff shortages, communications etc, and a further more detailed report will be circulated to staff.

4.3 The Workforce & OD department will undertake 'HR Workshops' on 1st March in RGH and 2nd March in PCH. This will enable access to one-to-one confidential advice for staff with a member of the HR team to discuss issues raised in the survey or any other matters.

5. Further Analysis of Free Text Questions

5.1 The purpose of this report is to provide the detail of the information from the two free text questions in the form of 'themes' that are emergent from the responses.

5.2 A further reason to group together the responses is to ensure full anonymity and confidentiality for all the individuals who provided comment.

5.3 Some of the comments have been reproduced 'verbatim' which alleviates any criticisms that the comments have been 'watered down' and increases confidence that concerns are genuinely being listened to.

5.4 To support the comments, where applicable, the percentage response rates to the questions in the survey have been included.

5.5 A total of 71 staff provided comments to Question 26 and a total of 68 staff provided comments to Question 27.

6. Themes in response to concerns that staff may have

6.1 Supervision / Investigations / Blame Culture

6.1.1 Responses indicate that staff are frightened that they are going to be investigated and placed on suspension, even when there are no adverse events. This is in some way due to the number of investigations going on in the workplace, and they are consequently working defensively.

> "I feel anxious the majority of the time I am in work and feel that any small mistake that is made will be investigated and I feel constantly watched and our work scrutinized."

6.2 Inadequate Staffing / Staffing Shortages

6.2.1 Responses consistently and repeatedly indicate that the workplace feels unsafe and that women are receiving care of a standard that is unacceptable. Many responses state that despite compliance showing 7 qualified members of staff on each shift, that the norm is usually only four qualified staff and on some occasions three staff to cover the ward, labour ward and birth centre. This is reported as overwhelming and too difficult to manage and a source of stress and anxiety.

> "Understaffed, feeling unsafe, stressed, anxious, taking on too much and not having enough time to complete work to a high standard."

6.2.2 Response to Question 10 "Do you have time to carry out all of your work?"

- From a total of 82 respondents 73 (89%) answered no.

6.2.3 Response to Question 21 "Are there enough staff for you to complete your work properly?"

- From a total of 81 respondents 74 (91%) answered no.

6.3 Management (above Band 7)

6.3.1 Responses indicate that staff do not feel that senior management understands what is happening on the shop floor, and that they do not listen. The staff feel that they are not involved in decision making, and they do not feel valued. There is a lack of trust for senior clinical midwives from managers.

"We will continue to support each other and continue to provide our women and families with the best care we can. Our managers need to be aware that it's really tough on the ground."

6.3.2 Response to Question 7 “Are you able to make improvements when you see the need for them?”

- From a total of 79 respondents 57 (72%) answered no.

6.3.3 Response to Question 8 “Have you been asked your opinion about changes that affect your work?”

- From a total of 81 respondents 53 (65%) said no.

6.3.4 Response to Question 13 “Do you feel managers encourage a culture of openness and trust?”

- From a total of 80 respondents 68 (85%) said no.

6.3.5 Response to Question 14 “Are you encouraged to have ideas and make them happen?”

- From a total of 80 respondents 58 (73%) said no.

6.3.6 Response to Question 15 “Are you involved in planning and developing what needs to happen?”

- From a total of 79 respondents 64 (81%) said no.

6.3.7 Response to Question 16 “Are you involved in discussion and decisions on how things need to be done?”

- From a total of 82 respondents 60 (73%) said no.

6.3.8 Response to Question 17 “Do you feel listened to and that you have a voice?”

- From a total of 81 respondents 70 (86%) said no.

6.4 Management (Band 7)

6.4.1 Responses indicate that staff feel supported by the Band 7s and that they are approachable if they have concerns. However, there are many comments that the Band 7s do not have time to carry out their role fully, this is indicated by their subordinates and recognised by the Band 7s themselves. There is pressure on senior Band 6s to act up in the absence of a Band 7, without appropriate

remuneration. There are also some comments here that Band 7s are sent to work in RGH, leaving PCH short of staff.

"As a band 7 I should be coordinating on shift but regularly am responsible for clients of my own. I am then struggling to support the many junior members of staff we have."

6.4.2 Response to Question 6 "Do you get regular feedback about how you are doing?"

- From a total of 81 respondents 66 (81%) said no.

6.4.3 Response to Question 12 "Do you have clear, planned goals and objectives that have been agreed and can be referred back to?"

- From a total of 82 respondents 43 (52%) answered no.

6.4.4 Response to Question 22 "Do you get enough support from you Line Manager?"

- From a total of 79 respondents 55 (69%) said no.

6.4.5 Response to Question 23 Does your Line Manager treat you with respect?"

- From a total of 79 respondents 47 (59%) said yes.

6.5 Bullying

6.5.1 Responses indicate that staff are scared to raise concerns, that there is a culture of bullying and staff being criticised.

6.5.2 Response to Question 24 "In the past 12 months have you personally experienced….."

- Harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public – from a total of 39 respondents 30 (77%) answered yes.

- Harassment, bullying or abuse at work from manager / team leader or other colleagues – from a total of 39 respondents 26 (67%) answered yes.

- Physical violence at work from any one of the following; Patients / service users or other members of the public – a total of 39 respondents 4 (10%) answered yes

- Physical violence at work from any one of the following: Manager / team leader or other colleagues – from a total of 39 respondents 1 answered yes

6.6 Recording of Sickness / Annual Leave / Rosters

6.6.1 Responses indicate that sickness is not being managed properly, that the rosters are undertaken by a Band 4 secretary and that this is inappropriate. There are concerns about the booking of annual leave and allocation of leave.

"Cycle of stress in work - high sickness means extra workload for those in with no additional support or encouragement from management. This leads to more sickness both from feeling like you can't work any harder and feeling completely unappreciated."

6.6.2 Response to Question 18 "During the past 12 months have you been injured or felt unwell as a result of work related stress?"

- From a total of 81 respondents 49 (60%) answered yes.

6.6.3 Response to Question 19 "In the past 3 months have you come back to work despite not being well enough to perform your duties?"

- From a total of 81 respondents 42 (52%) answered yes.

6.7 Shifts / Bank / TOIL

6.7.1 Responses indicate that staff are always willing to cover extra shifts to support their colleagues, and that some bank shifts have not been paid. In addition, time off in lieu is an issue for either payment or being given.

"Working over hours above and beyond but still being told we owe hours or bank shifts not getting paid."

6.8 Newly Qualified Staff

6.8.1 Responses indicate that there is a lack of support for newly qualified staff, and that they are left to sink or swim. Some of the comments are from the newly qualified themselves, and there are numerous comments from more senior staff expressing concern that there is no time to give them the support they require.

"I have worked as a qualified midwife at RGH for 14 months. I want to point out that I trained here since 2012 and I have never experienced working here so stressful and morale so low."

6.9 Team / Peer Support

6.9.1 Responses from the staff indicate that they feel they are a very dedicated team and that they support each other.

"As a team on the shop floor our commitment to each other and the clients is faultless and our team approach is second to none."

6.9.2 Response to Question 9 "Do you get good support from your colleagues?"

- From a total of 81 respondents 66 (83%) answered yes.

6.10 Morale / Thinking of Leaving

6.10.1 Responses indicate that staff are lacking in motivation and are emotionally and physically exhausted. There are numerous comments regarding not only leaving the Health Board but also leaving midwifery. Reasons for leaving are reported as high levels of anxiety and stress due to staff shortages and fear of losing registration because of staffing levels.

"I have always loved my job and have felt very blessed to be part of a close, strong working team providing care to women during such a special time in their life. Over the last year my passion and enthusiasm for my job has been challenged, causing me to consider leaving a profession which I worked very hard to be a part of."

6.10.2 Response to Question 4 "Are you satisfied with your current job?

- From a total of 79 respondents 46 (58%) answered no.

6.10.3 Response to Question 5 "Do you look forward to going to work?"

- From a total of 79 respondents 59 (75%) answered no.

6.10.4 Response to Question 20 "Do you feel valued and appreciated?"

- From a total of 79 respondents 65 (82 %) answered no.

6.10.5 Response to Question 25 "Would you recommend others to come to work for your department?"

- From a total of 76 respondents 58 (74%) answered no.

6.11 Community

6.11.1 Responses indicate that there is a constant need to fill gaps in staff in acute areas, resulting in Community work suffering. There is low morale as staff feel they are being used.

"Being pulled into acute after a full day on Community, minimal staff on call and depleted staff the following day."

7. Suggestions for Improvement

7.1 A well stocked and working kitchen facility on Ward 21.

7.2 Regular department meetings, allowing people to give input into the running of the unit ; Regular staff meeting – staff can be told about changes and feel comfortable making suggestions and challenging decisions ; Being involved in changes rather than enforcement.

7.3 More staff ; correct number of staff rostered to work on each shift ; Nursery nurse by night.

7.4 MDAU to be a unit of their own not using Ward 21 ; Open DAU for 12 hours and run triage from there ; A change in layout of the unit ; Split ante-natal and post-natal to two wards ; Triage nurse to take the in outers.

7.5 Online, confidential tool to report bullying without fear of retribution ; Confidential link contact in HR or elsewhere for staff to raise concerns.

7.7 Sickness training, explain the policy.

7.8 Staff to be offered debriefing sessions, requested when they feel it is needed.

7.9 Investigations – reduction in timescales.

7.10 Obstetric teaching on indications for induction ; More teaching

7.11 Management to spend significant time on the unit ; Improved communication from senior team ; Consistently sending copies of positive feedback from patients to staff ; more positive feedback from managers.

7.12 Stop partners staying at night.

7.13 Self rostering ; off duty to be done by Band 7 ward staff allowed to manage the shop floor and given back their clinical leads ; Mechanism for discussion of other options if shift patterns cannot be accommodated ; Annual leave to be booked no earlier than six months in advance ; Pay bank shifts on time.

7.14 Do not see concerns as failures but identified risks that can be improved ; Stop using the threat of suspension and disciplinary action over every aspect of the working day.

8. Next Steps

8.1 The first meeting of the Maternity Voices Forum will take place on **27th March 2017 at 9.30am in the Board Room at Prince Charles Hospital.**

8.2 The purpose of the Forum will be to improve communications within the Department, and to resolve the issues raised in the survey through the themes that have been outlined. The membership of the Forum will consist of:

- Head of Midwifery
- Nominated Senior Midwife
- Senior Business Partner, Workforce & OD
- HR Adviser for Maternity
- Nominated members of staff from PCH Acute, RGH Acute and Community/Birth Centre/Ante-natal with representative grades from Band 2/3/4 , Band 5/6 and Band 7 from each of those areas
- Trade Union Representatives from UNISON, RCN, UNITE and RCM

If you have any concerns regarding issues raised from this survey, or any other matters you wish to discuss in confidence, please contact your Workforce & OD Team:

Deborah Porter,Senior Business Partner
James Coglan, Business Partner
Rebecca Watkins, Assistant Business Partner
Amanda Jenkins, HR Adviser

What's Work Like For You

Pulse Survey Report for Maternity Department (Part One)

Workforce & OD
19th January 2017

1. Purpose of the Pulse Survey "What's Work Like For You"

1.1 In October and November 2016, some issues were raised by Maternity staff which needed to be resolved, and as some of these issues were raised anonymously they were difficult to investigate and resolve.

1.2 It was decided that the first stage in resolving these issues would be to take a pulse survey of Maternity staff which would help to establish the scope and range of issues that needed to be resolved.

2. Methodology

2.1 The Workforce & OD Department designed a questionnaire using Survey Monkey, with full co-operation from the Trade Unions. The survey opened on Friday 25th November, 2016, initially for two weeks, however it was extended until it closed on 6th January 2017. The survey was accessed via a link contained in emails sent directly to each member of staff.

2.2 Staff were assured that any member of staff, of any grade, could speak to the Head of Midwifery, Rachel Fielding, without fear for their position and in confidence, so that their concerns could be understood and investigated. Staff were also reminded that their trade union representatives were there to provide support.

2.3 Each member of staff would receive a copy of the Survey Report which would be available approximately four weeks after the survey closed.

3. Findings

3.1 A total of 82 staff responded to the survey, which from a total of 212 staff currently employed in the Directorate as a whole represents a 39% response rate.

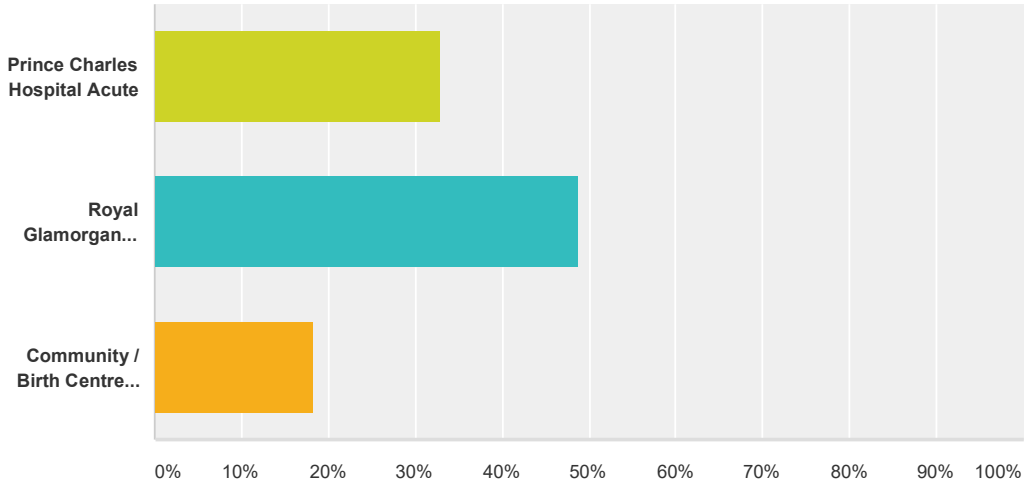
3.2 The highest number of responses were from RGH Acute with 48.7%, followed by PCH Acute with 32.9% and Community/Birth Centre/Ante-Natal with 18.2%.

3.2 Response rates related to Bandings were the highest amongst Band 5/6 with 58.5%, followed by Band 7 with 21.9 % and Bands 2/3/4/ with a 19.5%response rate.

3.2 The complete findings are set out in the following tables from Question One through to Question Twenty-five:

Q1 Where do you work?

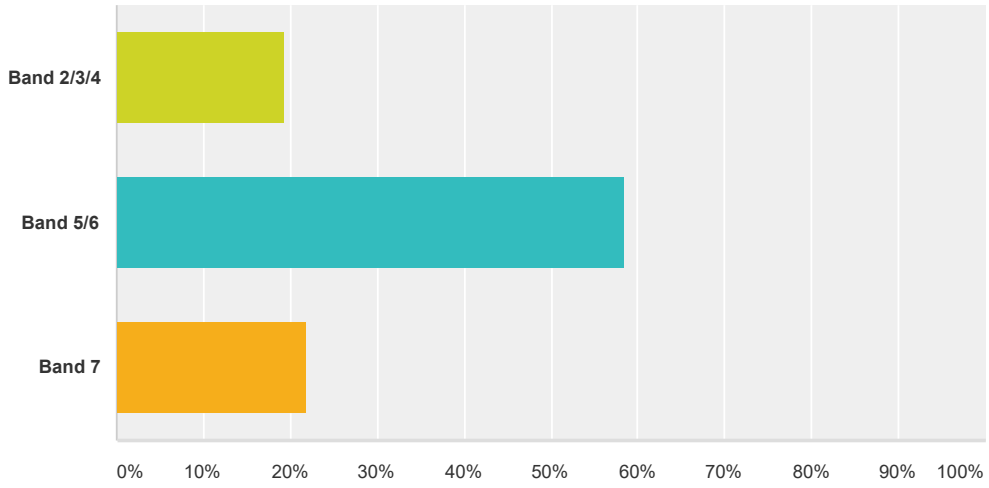
Answered: 82 Skipped: 0



Answer Choices	Responses	
Prince Charles Hospital Acute	**32.93%**	27
Royal Glamorgan Hospital Acute	**48.78%**	40
Community / Birth Centre / Ante-Natal	**18.29%**	15
Total		**82**

Q2 What Band are you?

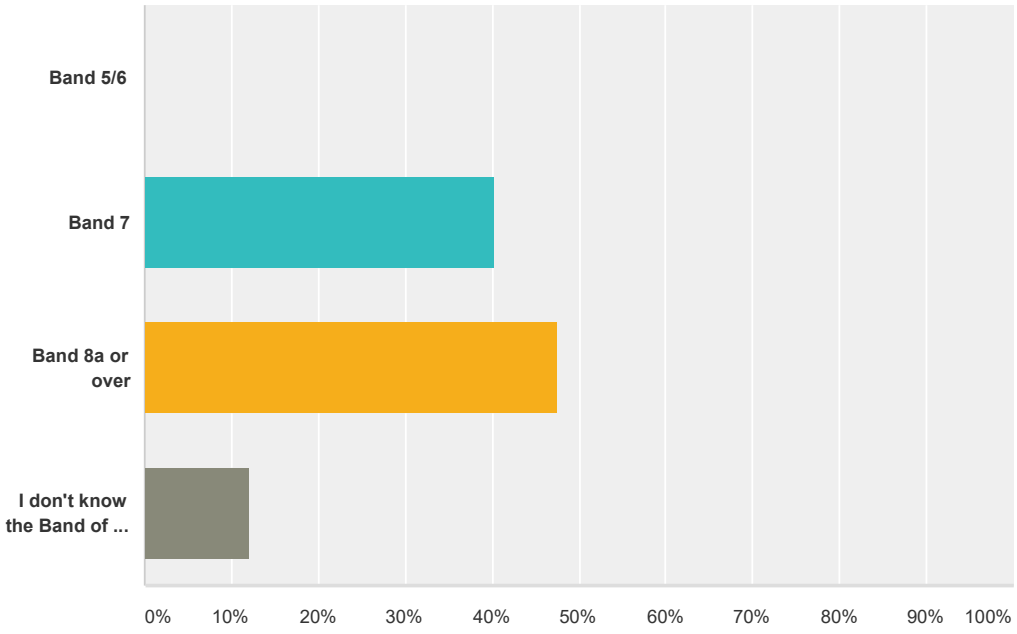
Answered: 82 Skipped: 0



Answer Choices	Responses	
Band 2/3/4	**19.51%**	16
Band 5/6	**58.54%**	48
Band 7	**21.95%**	18
Total		**82**

Q3 What Band is your direct Line Manager?

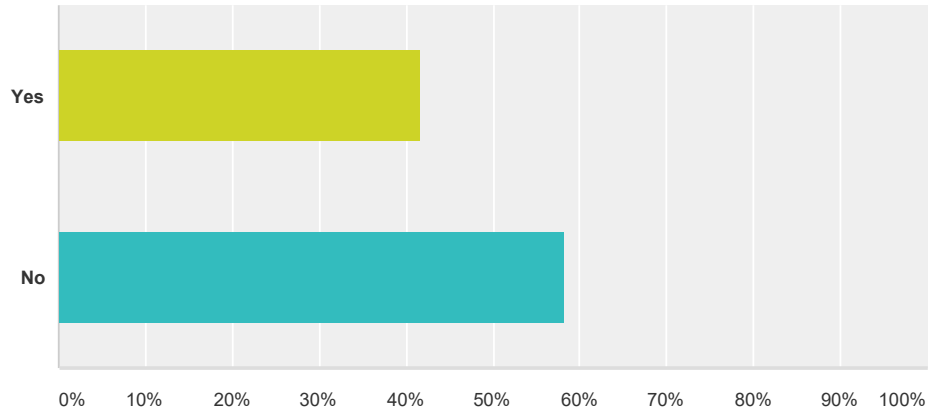
Answered: 82 Skipped: 0



Answer Choices	Responses	
Band 5/6	**0.00%**	0
Band 7	**40.24%**	33
Band 8a or over	**47.56%**	39
I don't know the Band of my direct Line Manager	**12.20%**	10
Total		**82**

Q4 Are you satisfied with your current job?

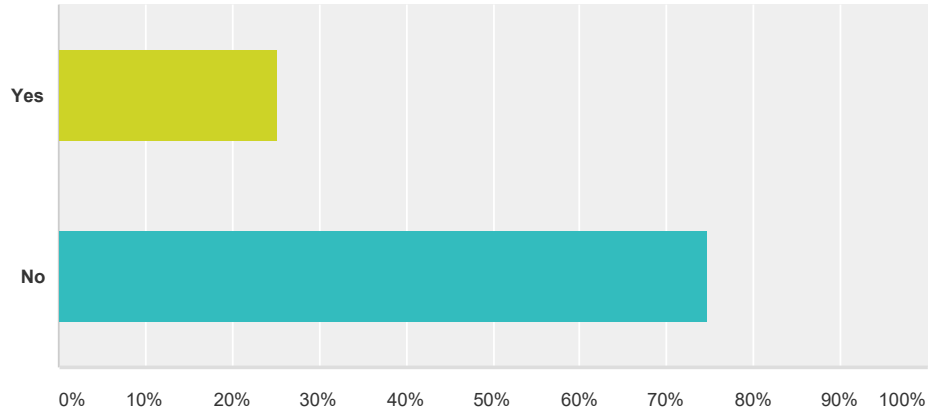
Answered: 79 Skipped: 3



Answer Choices	Responses	
Yes	**41.77%**	33
No	**58.23%**	46
Total		**79**

Q5 Do you look forward to going to work?

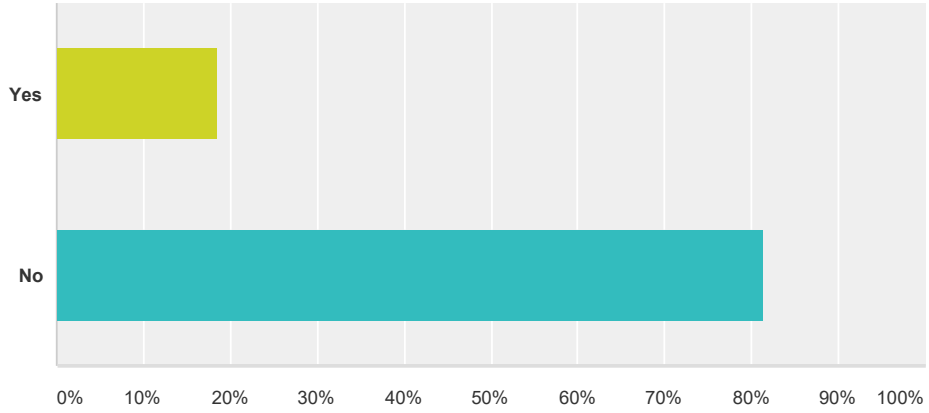
Answered: 79 Skipped: 3



Answer Choices	Responses	
Yes	**25.32%**	20
No	**74.68%**	59
Total		**79**

Q6 Do you get regular feedback about how you are doing?

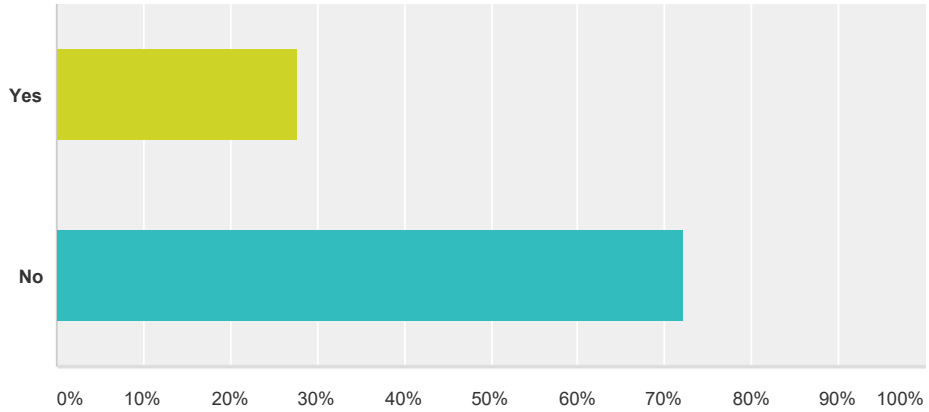
Answered: 81 Skipped: 1



Answer Choices	Responses	
Yes	**18.52%**	15
No	**81.48%**	66
Total		**81**

Q7 Are you able to make improvements when you see the need for them?

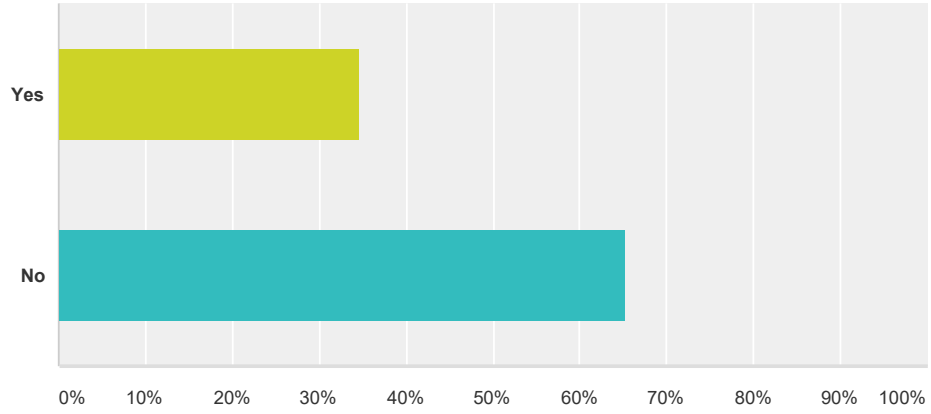
Answered: 79 Skipped: 3



Answer Choices	Responses	
Yes	**27.85%**	22
No	**72.15%**	57
Total		**79**

Q8 Have you been asked your opinion about changes that affect your work?

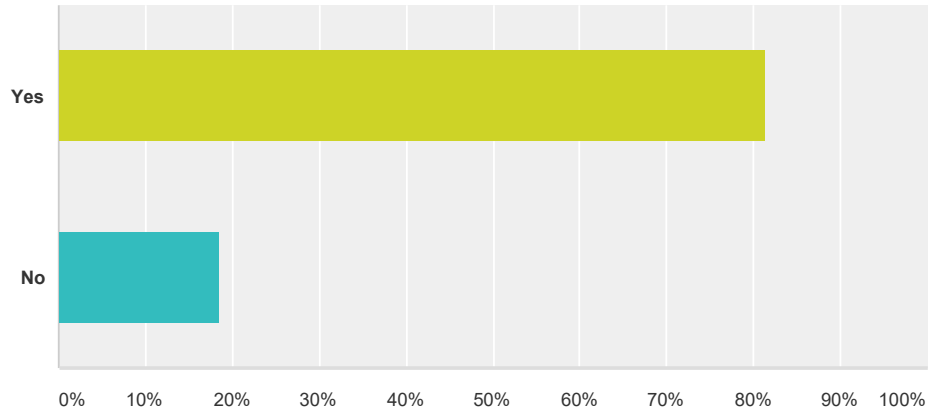
Answered: 81 Skipped: 1



Answer Choices	Responses	
Yes	**34.57%**	28
No	**65.43%**	53
Total		**81**

Q9 Do you get good support from your colleagues?

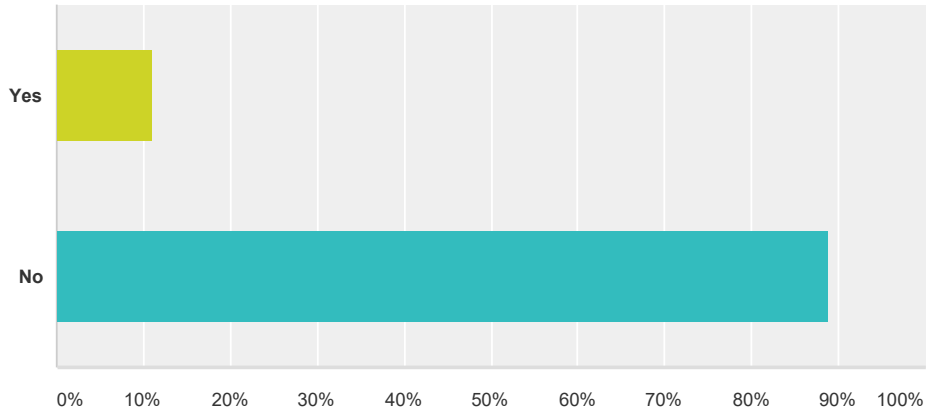
Answered: 81 Skipped: 1



Answer Choices	Responses	
Yes	**81.48%**	66
No	**18.52%**	15
Total		**81**

Q10 Do you have time to carry out all of your work?

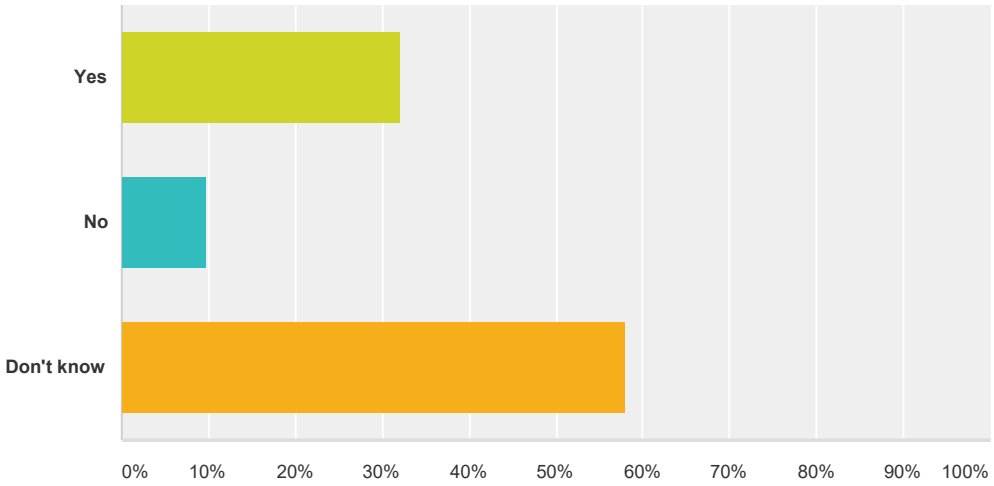
Answered: 82 Skipped: 0



Answer Choices	Responses	
Yes	**10.98%**	9
No	**89.02%**	73
Total		**82**

Q11 Does your direct Line Manager trust you?

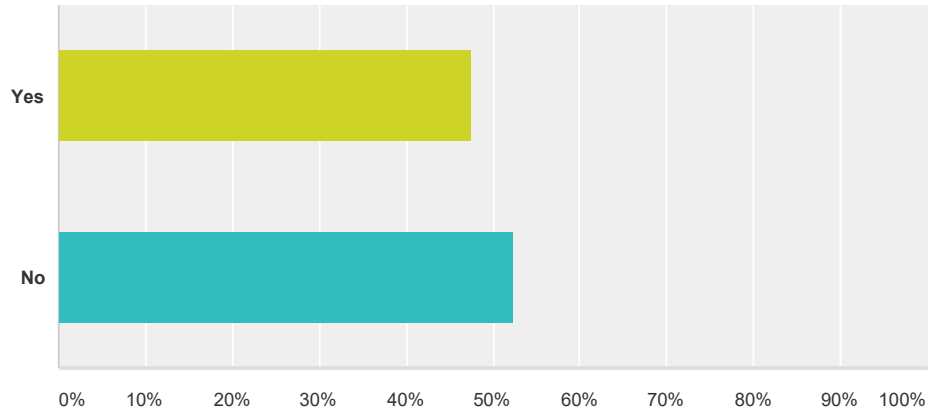
Answered: 81 Skipped: 1



Answer Choices	Responses	
Yes	**32.10%**	26
No	**9.88%**	8
Don't know	**58.02%**	47
Total		**81**

Q12 Do you have clear, planned goals and objectives that have been agreed and can be referred back to?

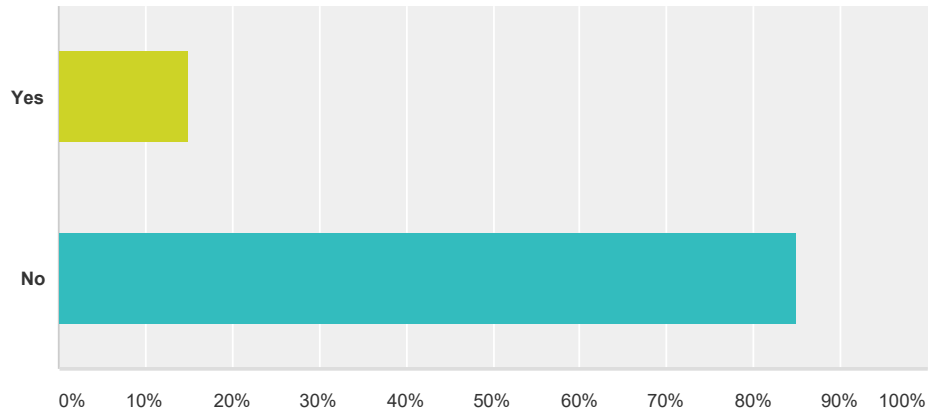
Answered: 82 Skipped: 0



Answer Choices	Responses	
Yes	**47.56%**	39
No	**52.44%**	43
Total		**82**

Q13 Do you feel managers encourage a culture of openness and trust?

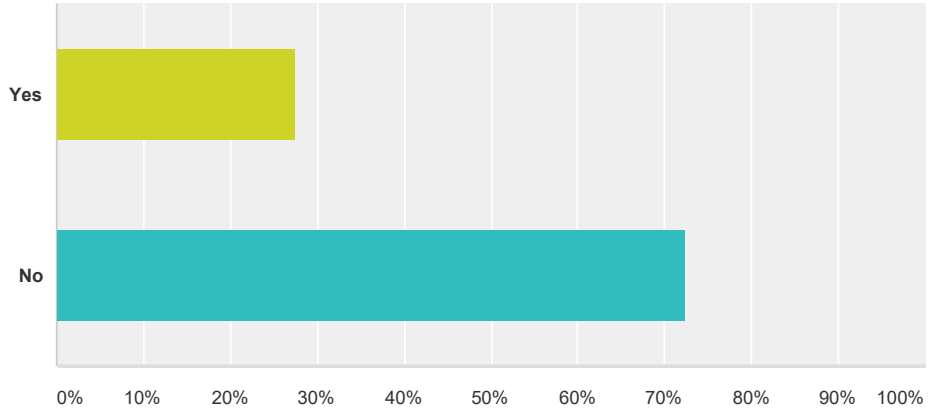
Answered: 80 Skipped: 2



Answer Choices	Responses	
Yes	**15.00%**	12
No	**85.00%**	68
Total		**80**

Q14 Are you encouraged to have ideas and make them happen?

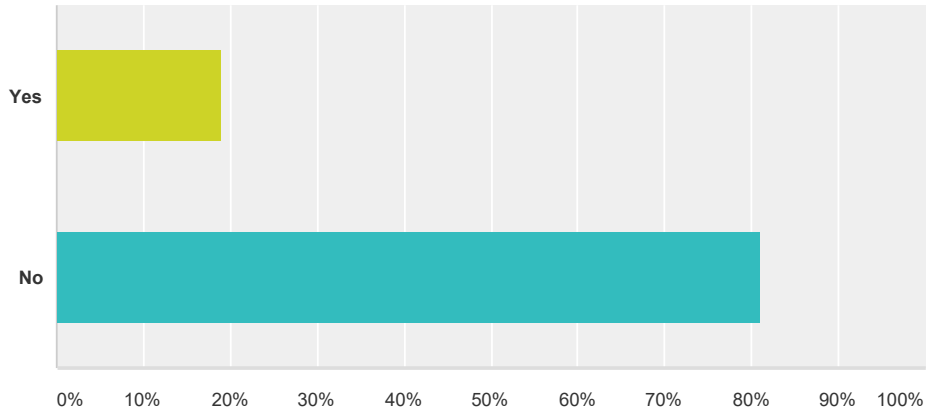
Answered: 80 Skipped: 2



Answer Choices	Responses	
Yes	**27.50%**	22
No	**72.50%**	58
Total		**80**

Q15 Are you involved in planning and developing what needs to happen?

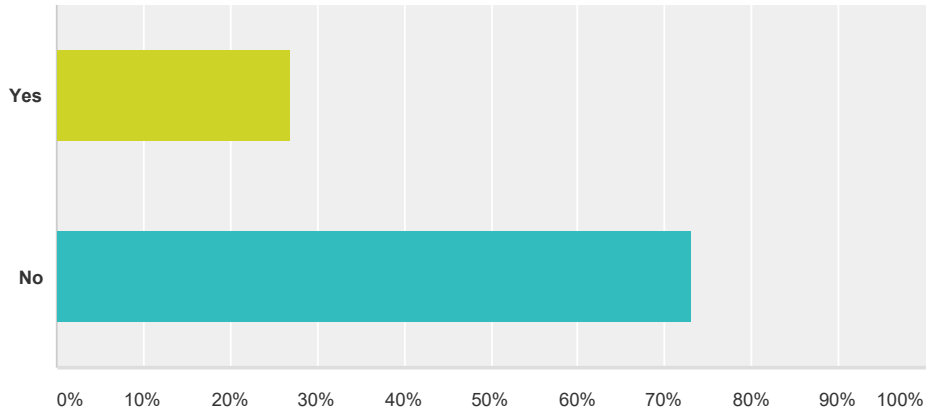
Answered: 79 Skipped: 3



Answer Choices	Responses	
Yes	**18.99%**	15
No	**81.01%**	64
Total		**79**

Q16 Are you involved in discussion and decisions on how things need to be done?

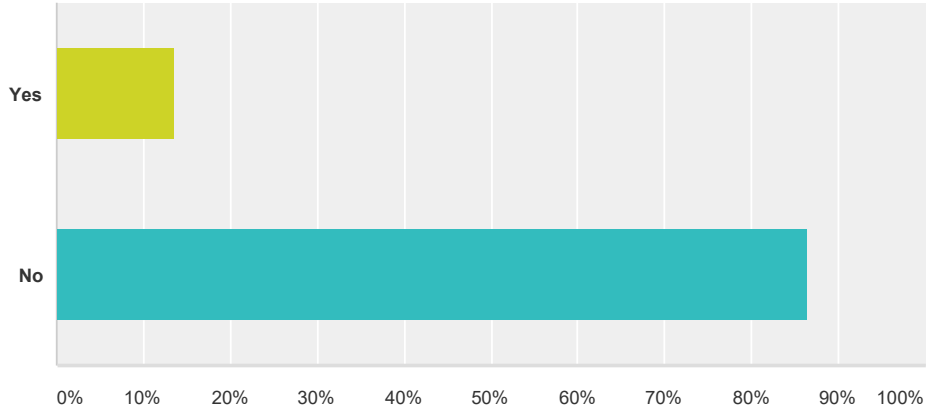
Answered: 82 Skipped: 0



Answer Choices	Responses	
Yes	**26.83%**	22
No	**73.17%**	60
Total		**82**

Q17 Do you feel listened to and that you have a voice?

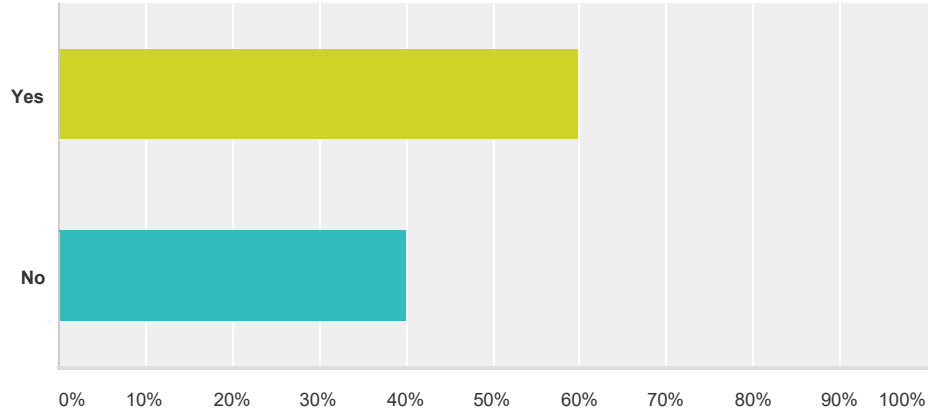
Answered: 81 Skipped: 1



Answer Choices	Responses	
Yes	**13.58%**	11
No	**86.42%**	70
Total		**81**

Q18 During the past 12 months have you been injured or felt unwell as a result of work related stress?

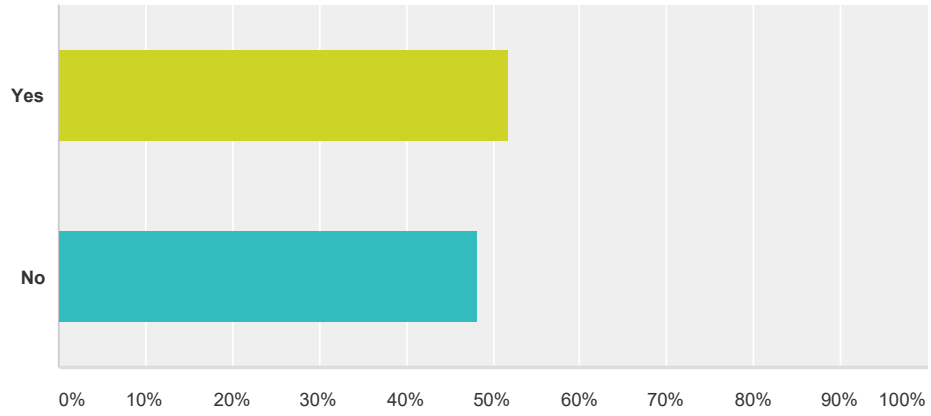
Answered: 81 Skipped: 1



Answer Choices	Responses	
Yes	**60.49%**	49
No	**39.51%**	32
Total		**81**

Q19 In the past 3 months have you come back to work despite not being well enough to perform your duties?

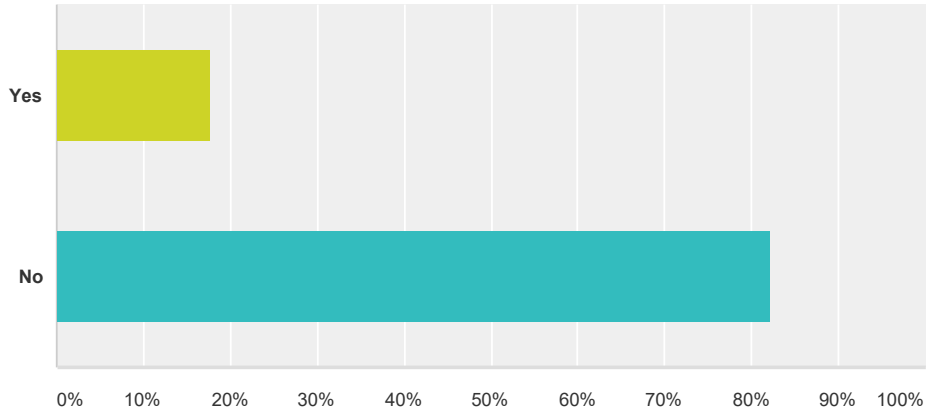
Answered: 81 Skipped: 1



Answer Choices	Responses	
Yes	**51.85%**	42
No	**48.15%**	39
Total		**81**

Q20 Do you feel valued and appreciated?

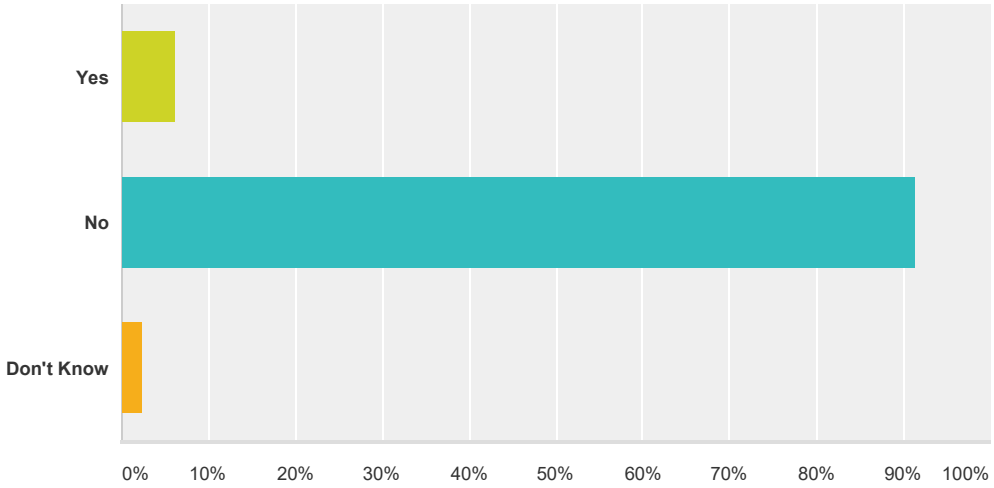
Answered: 79 Skipped: 3



Answer Choices	Responses	
Yes	**17.72%**	14
No	**82.28%**	65
Total		**79**

Q21 Are there enough staff for you to complete your work properly?

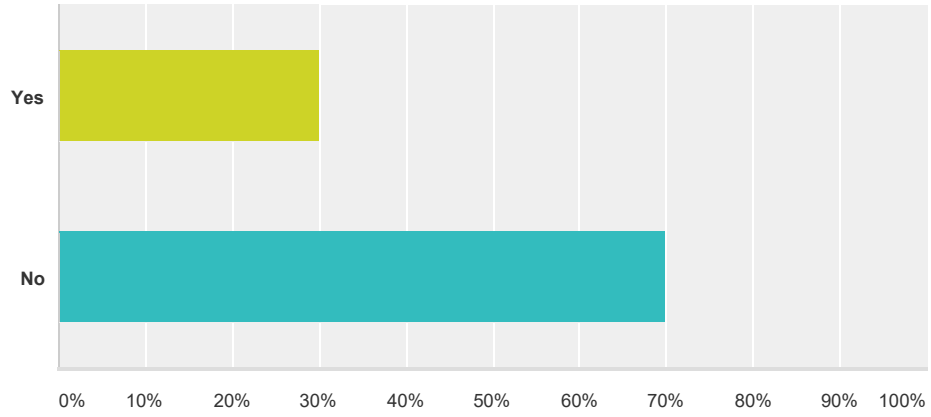
Answered: 81 Skipped: 1



Answer Choices	Responses	
Yes	**6.17%**	5
No	**91.36%**	74
Don't Know	**2.47%**	2
Total		**81**

Q22 Do you get enough support from your Line Manager

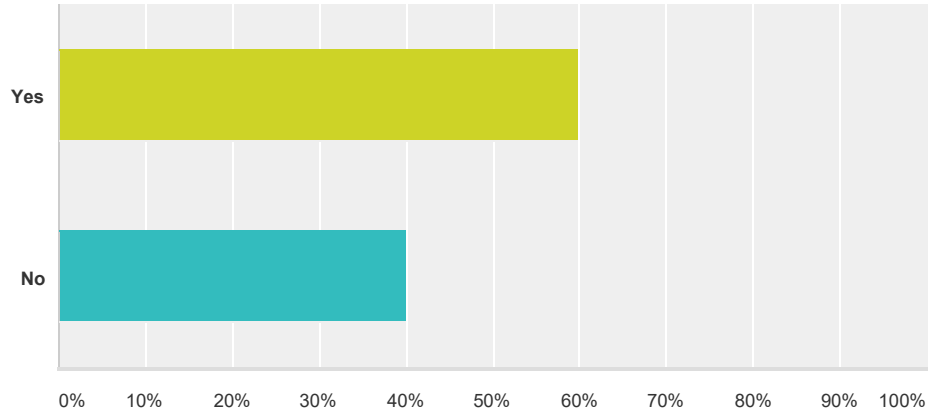
Answered: 79 Skipped: 3



Answer Choices	Responses	
Yes	**30.38%**	24
No	**69.62%**	55
Total		**79**

Q23 Does your Line Manger treat you with respect?

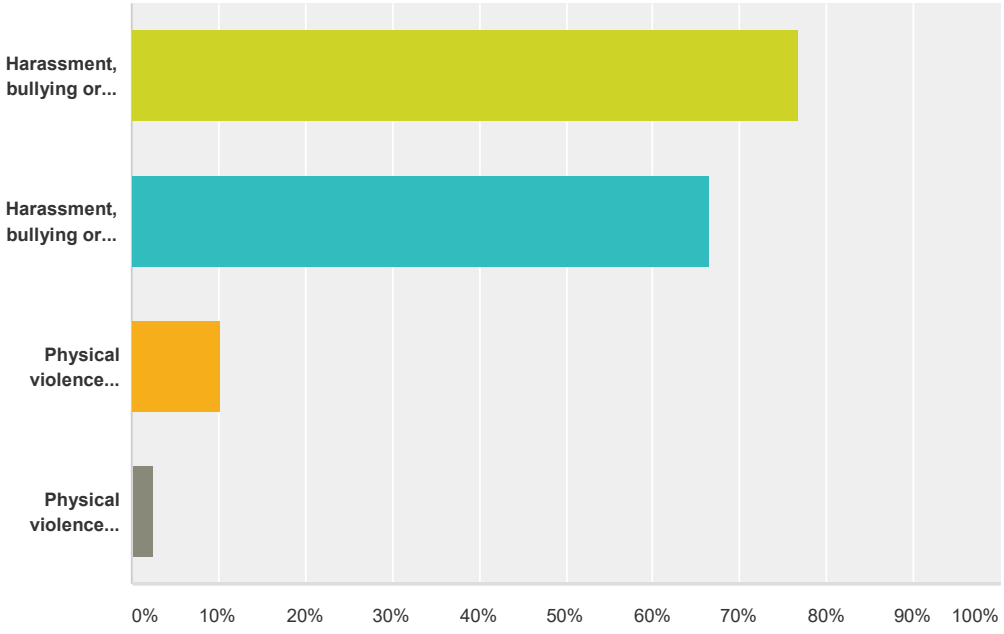
Answered: 79 Skipped: 3



Answer Choices	Responses	
Yes	**59.49%**	47
No	**40.51%**	32
Total		**79**

Q24 In the past 12 month have you personally experienced ...

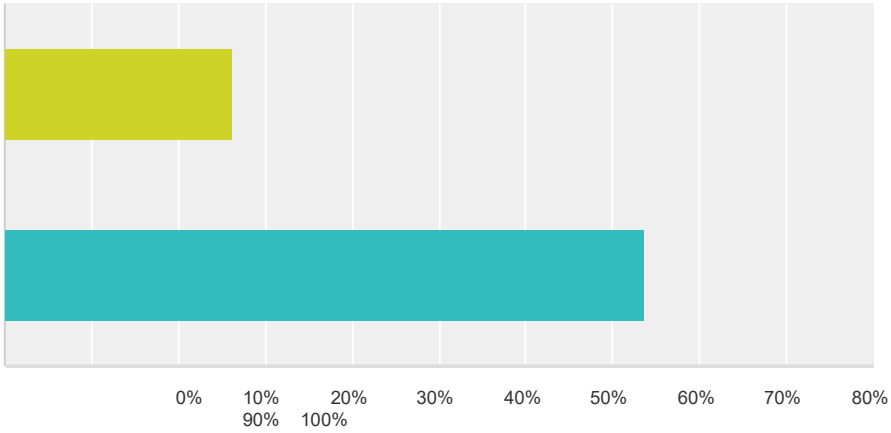
Answered: 39 Skipped: 43



Answer Choices	Responses	
Harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?	**76.92%**	30
Harassment, bullying or abuse at work from manager / team leader or other colleagues?	**66.67%**	26
Physical violence at work from any one of the following: Patients / service users or other members of the public?	**10.26%**	4
Physical violence at work from any one of the following: Manager / team leader or other colleagues?	**2.56%**	1
Total Respondents: 39		

Q25 Would you recommend others come to work for your department?

Answered: 76 Skipped: 6



Answer Choices	Responses
Yes	**26.32%**
No	**73.68%**
Total	

4. Next Steps

4.1 Further analysis of the findings will be undertaken by the Workforce & OD department, particularly regarding the free text questions:

Question 26 Please describe any concerns you may have

Question 27 Please describe any suggestions for improvement

Emergent themes will be identified, such as staff shortages, communications etc, and a further more detailed report will be circulated to staff by 31st January 2017.

4.2 A Maternity Voices Forum will be created and the inaugural meeting will take place in February 2017. The purpose of the Forum will be to improve communications within the Department, and to resolve the issues raised in the survey through the themes. The membership of the Forum will consist of:

- Head of Midwifery
- Nominated Senior Midwife
- Senior Business Partner, Workforce & OD
- HR Adviser for Maternity
- Nominated members of staff from PCH Acute, RGH Acute and Community/Birch Centre/Ante-natal and representative grades from Band 2/3/4 , Band 5/6 and Band 7
- Trade Union Representatives from UNISON, RCN and RCM

4.3 The Workforce & OD department will undertake 'HR Clinics' within the Department on both sites for one morning per week for a minimum period of four weeks from 30th January 2017. This will enable access to one-to-one confidential advice for staff with a member of the HR team to discuss issues raised in the survey or any other matters.

If you have any concerns regarding issues raised from this survey, or any other matters you wish to discuss, please contact:

Rachel Fielding, Head of Midwifery

or

your Workforce & OD Team

Deborah Porter,Senior Business Partner
James Coglan, Business Partner
Rebecca Watkins, Assistant Business Partner
Amanda Jenkins, HR Adviser

CWM TAF COMMUNITY HEALTH COUNCIL (CHC) INSPECTION VISITS
- ISSUES RAISED -

DATE OF INSPECTION VISIT	5/2/18	**DATE REPLY SENT TO CHC**	
SITE AND WARD/DEPARTMENT INSPECTED	Maternity and Neonatal Wards, PCH		
STAFF MANAGER	Lisa Grant		

REFERENCE NO	ISSUE RAISED BY CHC	RESPONSE BY HB	HB LEAD
PCH-MAT/NEO-01	The CHC understands that patient satisfaction surveys are undertaken and would like to know if any women have expressed dissatisfaction with the current arrangements.	Midwives encourage every patient to complete a patient satisfaction survey (either hard copy or on-line) whilst in hospital or in the comfort of their own home. Since the relocation of these services, there were 724 births but only four surveys were returned. None of the surveys received indicated any dissatisfaction with the current arrangements. In terms of formal or informal complaints, none have been received in respect of the current arrangements.	Debbie Griffiths Acting Head of Midwifery PALS Team
PCH-MAT/NEO-02	The CHC was concerned about the apparent lack of accommodation for parents of babies in the neonatal unit.	Accommodation is available for parents who wish to stay in the Unit whilst their baby is being cared for in the Neonatal Unit. We have a dedicated side room with en suite facilities on Ward 34 and other rooms within the Unit, if required.	As above

CWM TAF COMMUNITY HEALTH COUNCIL (CHC) INSPECTION VISITS
- ISSUES RAISED -

REFERENCE NO	ISSUE RAISED BY CHC	RESPONSE BY HB	HB LEAD
		To date, we have supported all requests and have had no complaints regarding the lack of suitable accommodation to support their stay.	
PCH-MAT/NEO-03	The CHC talked to one member of the midwifery staff and one of the consultants. From those discussions, CHC members were concerned that there appeared to be limited engagement with the staff on the temporary arrangements.	As part of the planning process for these moves, we held weekly meetings with the clinical multidisciplinary teams, which also included representatives from theatres, portering, estates, facilities, pharmacy and IT. Action notes were made available to all and disseminated to the wider teams via ward managers and clinical leads. In addition, the multidisciplinary team was fully engaged in the "dry run drills" that took place prior to the service relocation to Wards 19 & 34 to test the process and provide reassurance to all that safe transfer was possible in a timely manner in response to emergency situations.	**Medical staff** Jonathan Pembridge Consultant Obstetrician and Gynaecologist **Midwifery staff** Debbie Griffiths Acting Head of Midwifery

CWM TAF COMMUNITY HEALTH COUNCIL (CHC) INSPECTION VISITS
- ISSUES RAISED -

REFERENCE NO	ISSUE RAISED BY CHC	RESPONSE BY HB	HB LEAD
		Engagement with staff has been continuous across both RGH and PCH sites with regard to the planned changes to these services, i.e. Paediatrics, Obstetrics and Neonates. The methods employed to engage our staff are 1:1s with HR, circulation of staff briefings, CEO blogs, SharePoint and all staff meetings (the next one takes place in May 2018).	
PCH-MAT/NEO-04	Based upon feedback from one Consultant on duty at the time of the visit, the CHC is concerned about the apparent lack of communication between the Clinical Director and Consultants at PCH.	The Clinical Director holds quarterly meetings with all Consultants; for example, the last two meetings were held on 13/12/17 and 7/3/18. We acknowledge that a Consultant may be covering a shift/clinic and hence may not be able to attend. However, all presentations and documents for these meetings are circulated to all Consultants. In addition to the above, Consultants are invited to smaller service planning meetings. To ensure communication channels are robust and effective, monthly	Jonathan Pembridge Consultant Obstetrician and Gynaecologist

REFERENCE NO	ISSUE RAISED BY CHC	RESPONSE BY HB	HB LEAD
		meetings with Consultants have now been established and will commence from April 2018. In addition, from May 2018, the Clinical Director will hold monthly one-to-one's with each Consultant.	
PCH-MAT/NEO-05	The CHC would appreciate an insight into the way that "spikes" in the number of still-births are investigated.	There is no national definition of what a 'spike' in stillbirths would be, however the Health Board would be particularly alarmed if more than two occurred in one month. Every single stillbirth is reported on Datix and reviewed to identify trends, initial concerns and early learning. Wider learning is shared with the team through newsletters and mandatory training. In addition to the reviews being undertaken, the following action is taken: • Launched 18 months ago, the Health Board embraced the Safer Pregnancy campaign in an effort to reduce the stillbirth rate within Wales. • Multi-professional stillbirth meetings commenced in 2017	Debbie Griffiths Acting Head of Midwifery Myfanwy Ellis Senior Midwife Quality

REFERENCE NO	ISSUE RAISED BY CHC	RESPONSE BY HB	HB LEAD

		and learning is shared through newsletters.
		• In February 2018, we established a new Stillbirth Forum, which meets monthly. Membership is multidisciplinary across all sites and includes anaesthetists and neonatologists to give a wider review and richer learning. This approach supports the recommendations in the following reports:
		  • Each Baby Counts (EBC) 2017 report
		  • Mothers and Babies Reducing Risk through Audit and Confidential Enquiries (MBRRACE) 2017 report
		  • All Wales Initiation to Reduce Stillbirths.
		• The 2018 Perinatal Mortality Review tool has recently been shared nationally and we will use this in the Stillbirth Forum to demonstrate thorough reviews and wider learning.	

Cwm Taf University Action plan following the LSA MO meetings with Midwifery staff in December 2016

Date developed	23rd December 2016
Date updated	27th January 2017
Monitored by	Head of Midwifery- Rachel Fielding Senior Midwifery Managers – [redacted] Supervisor of Midwife – [redacted]

Theme 1: **Staffing Levels**

Concern :
Deficient staffing levels within both maternity units in CTUHB

Concern	Current position	Action needed / in place	Monitoring Arrangements	Lead	Completion date	Update/ progress/ Evidence
Apparent staffing deficits across both sites reportedly affecting the safety of women and babies.	Birthrate plus compliant (this assessment was several years ago).	Birthrate plus assessment in place in December 2016. Findings due in January / February 2017.	Senior Midwives (acute)	RAF.	April 2017	**BR+ completed in 2017. 07.02.17** SL chased for evidence **27/01/2017** BR+ ongoing. Meeting in January 2017 identified further information required. Meeting arranged for March 2017

Theme 1 : **Staffing Levels**						
Concern : Deficient staffing levels within both maternity units in CTUHB						
Concern	**Current position**	**Action needed / in place**	**Monitoring Arrangements**	**Lead**	**Completion date**	**Evidence**
High risk antenatal women requiring one to one care apparently being cared for on the ward due to staffing on labour ward (PCH).	If 1:1 midwifery care is required for the high risk women the expectation is that they are cared for on the labour ward.	Complete one month audit to assess where 1:1 care is provided.	Senior Midwives (acute)	EMG HS / JS	February 2017	Audit tool providing high risk

Theme 2 : **Quality & Safety**						
Concern : Unable to provide safe effective care - this impacts patient safety						
Concern	**Current position**	**Action needed / in place**	**Monitoring Arrangements**	**Lead**	**date**	**Evidence**
Reported inability of Band 7 midwives to provide support for junior midwives as they are required to cover other areas of service e.g. Maternity Day Assessment Unit (MDAU). This could have a direct affect on patient safety.	Areas such as the MDAU are expected to have a dedicated midwife.	Review the midwifery cover for areas such as the MDAU / Triage and produce a report to reflect the current position (are band 7 midwives having to work in other areas and therefore unable to support junior midwives).	Senior Midwives (acute)	ZA	August 2017	 PCH Midwifery - Band 7s.pdf
Band 7 midwives reportedly providing one to one care in labour, whilst also trying to support midwives in the unit as the shift co-ordinator. This could have a direct affect on patient safety.	Band 7 midwife work as the shift co- coordinator and should not provide 1:1 care. There is an expectation for them to assist with care of the low risk woman.	Complete one month audit to assess whether the band 7 midwife provide 1:1 care.	Senior Midwives (acute)	EMG	February 2017	 Audit tool 1:1 midwife care

Theme 3: **Quality & Safety**						
Concern : Unable to provide safe effective care - this impacts patient safety						
Concern	**Current position**	**Action needed / in place**	**Monitoring Arrangements**	**Lead**	**date**	**Evidence**
Significant potential safety concerns in High Care (PCH) which reportedly does not have a dedicated midwife. The level of monitoring for these women necessitates one to one care but the Unit is reportedly staffed by 1 or 2 midwives making this unachievable.	Women cared for Bay 1 (PCH) are generally post CS. Women are recovered on labour ward for 1 -2 hours and then transferred to ward 21. If 1:1 care is required these women remain on labour ward.	Complete one month audit to assess whether women in high care in PCH require 1:1 care.	Senior Midwives (acute)	EMG HS/ JS	February 2017	

Theme 4: **Delay in Patient Care**						
Concern :						
Concern	**Current position**	**Action needed / in place**	**Monitoring Arrangements**	**Lead**	**date**	**Evidence**
Potential delays in care on MDAU, as women allegedly waiting two to three hours before being assessed (RGH).	Women attend MDAU (RGH) as necessary although time slots are available. The current average waiting time is not known	A `time arrival` and a `time assessed` has been added to the triage / MDAU sheet. Staff have been made aware of this and it has been placed on the safety briefing 22/12/2016	Senior Midwives (acute)	RP	December 2017	
		Complete one month audit to assess the average waiting time.	Audit / Guideline Midwife	EMG	February 2017	

Theme 5 : **Blame culture**						
Concern : Feeling undervalued and unsupported						
Concern	**Current position**	**Action needed / in place**	**Monitoring Arrangements**	**Lead**	**date**	**Update/ progress**
Midwives report feeling 'unsupported', 'fearful for their registration' and vulnerable and their view is that their concerns are not valued.	The Senior Management Team have an `Open door` policy and encourage staff to view their concerns and views HOM and the Senior Management team have unit meetings every 2 months to allow professionals to attend and express their views and share experiences.	To continue to support all staff and ensure time is given to listen to staff. Regular team meetings. Dates. Times and notes of all departmental and team meetings to be made available to staff. If staff are unable to attend staff are encouraged to send their views / concerns to a lead person so this can be discussed in the relevant meeting.	Senior Midwifery Managers Team	RAF	October 2016	**27/01/2017** 2017 dates have been circulated and displayed for staff to view. A meeting was arranged for January 2017. HOM / DON & Senior Midwife attended. 1 midwife in attendance. There is daily contact / visit to the clinical area by the Senior Midwife and Head of Midwifery. Contact details of the Senior Managers are available to all staff. .

Theme 5 : **Blame culture.**						
Concern : Feeling undervalued and unsupported.						
Concern	**Current position**	**Action needed / in place**	**Monitoring Arrangements**	**Lead**	**date**	**Evidence**
Reported reluctance to escalate concerns for fear of being criticised, this could have a direct affect on patient safety.	Datix reporting has always been good within the maternity department. There has not been a significant fall in the number of incidents reported. All Datix events are reviewed in an open and honest manner in line with CTUHB guidelines and the NMC code.	The Datix review process to be reviewed to allow more involvement by the band 7 midwives. This will hopefully reduce the fear culture that is said to be within the unit.	Senior Midwifery Managers Team	ME ZA DD DG JE SOM – RE / KA.	**January 2017** Review of Datix has been completed. Notices displayed in the clinical areas and band 7 leads asked to share in team meetings.	Datix review flowchart 2017 Trigger list The following report was shared after a Freedom of Information request. The number of Datix reported in 2016 and the level of harm 2016 Datix received relating to staffing f

Theme 6 : Professional Accountability						
Concern : Midwives unable to demonstrate professional accountability in line with the NMC Code (NMC 2015)						
Concern	**Current position**	**Action needed / in place**	**Monitoring Arrangements**	**Lead**	**date**	**Evidence**
Limited midwifery understanding demonstrated of professional accountability in line with the Code (NMC 2015).	To improve midwives understanding of professional accountability in line with the NMC code.	SOM to provide professional accountability update sessions in the clinical areas (in line with NMC code). Discussed at annual appraisal. Discussed as part of the revalidation process.	Senior Midwifery Managers Team	RE KA	January 2017	**27/01/2017** SOM provide group sessions where professional accountability update sessions in the clinical areas (in line with NMC code).

Theme 7 : **Training**						
Concern : Non compliance with mandatory training.						
Concern	**Current position**	**Action needed / in place**	**Monitoring Arrangements**	**Lead**	**date**	**Evidence**
Mandatory training compliance could be affected with suspension of the training in November and December 2016. This has the potential to affect midwives scope of practice and impact on patient safety.	Mandatory training is held monthly over 3 days. In November & December 2016 there have been mandatory training has been cancelled due to the inability to cover service needs. The remainder of the year training has continued to be held.	Training to be cancelled as a last resort. New midwives have been appointed and completed their induction programme in January 21017. It is anticipated that full compliance with training needs will then be achieved**.**	Senior Midwifery Managers Team	ZA DD DG JE	**27/01/2017** New midwives have a 4 week orientation programme and an induction booklet is given to each staff. Named preceptors identified. Training database in place. Mandatory training programme in place.	 Mandatory programme day 1 201  PROMPT 2016 - 2017  Mandatory Programme 2016 - 20

Theme 7 : **Training**						
Concern : Non compliance with mandatory training.						
Concern	**Current position**	**Action needed / in place**	**Monitoring Arrangements**	**Lead**	**date**	**Evidence**
Unknown compliance with the RCOG e-fm CTG training package as at the end of March 2016.	A database is in place which monitors CTG compliance. Midwives fail to present evidence of their training therefore the database is unable to reflect the true position of compliance.	All midwives have been informed that they are required to provide their certificate as evidence that they have completed RCOG EFM training package. Leads have been identified to monitor compliance and produce 3 monthly CTG update reports. Any midwife who does not provide evidence will have to explain this to the HOM.	Senior Midwifery Managers Team	**KH** **PG**	March 2017	 RCOG - EFM TRAINING.xlsx

KPI 6 Peer Review - Health Boards can demonstrate evidence that peer review of Clinical Supervision for Midwives is undertaken across Health Boards annually and that a lay reviewer is included as part of the review team

Main Principles

Each Health Board Self Reports using agreed Tool

Annually, each Health Board will host two CSfM from another Health Board to review their evaluation of service. Significant deviations from the self reported findings must be reported to the Welsh Government Nursing Officer for Maternity and Early Years and Head of Midwifery.

This Peer Review process is designed to encourage reflection and promote collaboration between Health Boards in developing the employer led supervision model.

Standards

	Standard	Evidence	Met / Not Met	Action Plan if not met
1.	Is there evidence that each CSfM has attended at least 3 of the quarterly All Wales CSfM Forum meetings in the last year? (KPI2)	Minutes of AWCSfMF show ¾ meeting attended by KA and ZA (RE retired midway through year).	**Met**	
2.	Is there evidence of up to 20% clinical time for each CSfM?	No	**Not Met**	CSfM to record in their electronic diaries when clinical time is worked
3.	Is there evidence that each CSfM has completed MSc/MA 20 credit module or equivalent accredited learning in a relevant leadership module?	No	**Not Met**	To enrol in academic year 2018/2019
4.	Each Midwife has a named CSfM	Currently only one CSfM	**Met**	
5.	The Ratio of Midwives to CSfM is at least 1:125	Currently only one CSfM seconded to Health Board, total number of midwives = 210. WTE 1.68 required	**Not Met**	To advertise for seconded CSfM ASAP
6.	Is there evidence that all midwives have attended 4 hours of supervision in the last year, two of which must be in Group Supervision (KPI3)	No. Evidence of 5/210 midwives attending since April 2017	**Not Met**	Run Group Supervision fortnightly. Pay staff to attend. Change format of mandatory training days to Governance Team session which will be hours 3 and 4.
7.	Is there evidence that all preceptor midwives have had at least 3 contacts with their CSfM during the first year of practice? (KPI4)	No. 3/12 Band 5 midwives have had any contact with CSfM according to database.	**Not Met**	Urgently make contact with Band 5 midwives and arrange contact.

8.	Is there evidence that all midwives at critical moments in their career have had CSfM contact? i.e. • Pending or following a change in role • Following a period of long term sickness or absence • When returning from maternity leave • When returning from a career break • For career advice or guidance	No evidence of this activity	**Not Met**	Request managers inform CSfM of any midwives returning to work after absence so that support can be offered
9.	Is there evidence of CSfM providing support to midwives with revalidation?	Some anecdotal evidence that this is happening	**Not Met**	Ensure midwives are aware that CSfM can assist with revalidation
10.	a. Are Group Supervision sessions accessible for midwives? b. Is time off in lieu offered for those attending during their own time?	Currently no sessions planned	**Not Met**	Urgently book group supervision sessions. HoM has agreed to pay for two hours, to be captured on electronic rostering system.
11.	a. Are Group Supervision sessions evaluated by attending midwives? b. Is there evidence that this feedback is assessed and acted upon?	No	**Not Met**	Commence use of All Wales CSfM Evaluation Tool from September 2018
12.	a. Are midwives views of the new model of supervision sought? b. Is there evidence that this feedback is assessed and acted upon?	Anecdotal evidence that midwives do not understand new model	**Not Met**	Plan to present evaluation of Group Supervision at least annually
13.	Do CSfM have a private space in which to hold discussions with midwives?	No	**Not Met**	Hot desking in shared offices
14.	Is there a database of each midwife's	Yes	**Met**	

	contacts with CSfM?			
15.	Are CSfM integrated into risk, governance, practice development?	Included as part of Senior Management Team but limited formal governance structure.	**Met**	Ongoing work to integrate two sites into one, senior team and governance structures evolving
16.	In Health Board's with more than one CSfM and / or more than one site, is there evidence of regular CSfM team meetings?	No	**Not Met**	Currently only one CSfM, to schedule regular team meeting when recruitment occurs
17.	Is there evidence that managers are leading the capability and conduct processes and the CSfM's are involved in a supportive capacity i.e. " not wearing two hats"	No. CSfM were involved in leading capability and conduct processes prior to 23/7/18.	**Not Met**	Seconded CSfM in place 23/7/18. Pre existing CSfM now work in governance / risk roles.
18.	Is there evidence that CSfM's are not involved in conducting RCA's or Investigations other than to support midwives e.g. with statement writing and learning. "not wearing two hats"	Strong evidence that CSfM were involved in decisions around capability / conduct up to 23/7/18	**Not Met**	Seconded CSfM in place 23/7/18. Pre existing CSfM now work in governance / risk roles.
19.	Is there evidence that lessons learnt from serious incidents and route causes analysis and general themes and trends from governance activities shared? (KPI5)	Strong evidence that lessons learnt from serious incidents are shared as part of mandatory training days. No evidence of sharing of themes and trends for learning	**Not Met**	Plans for more regular communication going forward, e.g. monthly newsletters, noticeboards, revised mandatory training and commence of group supervision.
20.	Is there evidence of CSfM(s) communicating regularly with midwives, e.g. newsletters	No	**Not Met**	Plans for more regular communication going forward, e.g. monthly newsletters, noticeboards, revised mandatory

				training and commence of group supervision.
21.	Is there a clear governance structure in place outlining CSfM responsibilities and accountability?	No	**Not Met**	Currently being developed by Interim Governance Manager
22.	Are CSfM involved in service improvement projects e.g. IQT Silver or equivalent level?	No	**Not Met**	Since 23/7/18 seconded CSfM has been involved in patient safety improvements projects improving PSAG boards, handovers and medication management

Standards

On external peer review, if any of the self assessed criteria above are found Not Met, then the external peer reviewer should document below by Standard Number what their findings were and what recommendations they suggest going forward.

These recommendations will form the basis of an approved Action Plan made in conjunction with the External Reviewer, the Health Board being reviewed and the Welsh Government Nursing Officer for Maternity and Early Years.

Obstetric, Gynaecology & Sexual Health Exception report to the Corporate Risk Committee
September 2016

Directorate/Locality	Obstetrics, Gynaecology & Sexual Health Directorate.
Chaired by	Mrs Rachel Fielding, Head of Midwifery, Gynaecology, Sexual Health, Neonatal & Paediatrics Mr Jonathan Pembridge Clinical Director / Consultant Obstetrician & Gynaecologist.
Lead Executive Director	Lynda Williams – Nurse Director
Date of last meeting	Directorate Quality & Safety Meeting – 10 th May 2016
Link to Health & Care Standard/s:	**STAYING HEALTHY** Standard 1.1 Health Promotion, Protection and Improvement **SAFE CARE** Standard 2.1 Managing Risk and Promoting Health and Safety Standard 2.4 Infection Prevention and Control (IPC) and Decontamination Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk **Effective Care** Standard 3.1 Safe and Clinically Effective Care Standard 3.2 Communicating effectively. Standard 3.3 Quality Improvement, Research and Innovation Standard 3.4 Information Governance and Communications Technology Standard 3.5 Record Keeping **DIGNIFIED CARE.** Standard 4.1 Dignified Care Standard 4.2 Patient Information **TIMELY CARE** Standard 5.1 Timely Access **INDIVIDUAL CARE** Standard 6.1 Planning Care to Promote Independence Standard 6.2 Peoples Rights Standard 6.3 Listening & Learning from Feedback **STAFF RESOURCES.** Standard 7.1 Workforce.

Summary of key matters considered by the group and any related decisions made.

This report informs the Quality & Safety Committee of the key matters relating to the Obstetric, Gynaecology & Sexual Health Directorate.

Obstetric, Gynaecology & Sexual Health

Key Issues.

Cwm Taf University Health Board Caesarean Section Rate (CSR).

The Directorate remains mindful of the need to reduce the CSR and maintain the rate below 25 % as per WAG target. This is on the agenda of the Senior Management Team and discussed at every Health Board Maternity Performance Meeting with Welsh Assembly Government and at Heads of Midwifery meetings. The Multidisciplinary team within the Directorate continues to demonstrate a commitment to reduce the CS rate whilst ensuring optimum outcomes for both Mother and Baby.

Since May 2016 Alongside Midwife Led Unit (AMU) are fully functional on both Acute maternity sites.

It is anticipated that supporting all low risk woman to provide care in a midwifery led environment in support of the WAG target of 45% will assit to reduce the CSR.

The CTUHB 2016 CSR available data is shown below.

Month	Jan	Feb	Mar	April	May	June	July
Total Births	338	335	335	318	327	317	354
Total CSR	**28.8**	**29.9**	**27.3**	**23.8**	**33.4**	**32.1**	**28.9**
Cat 1&2		13.9		10.8	15.9	10.6	12.4
%	14.5		10.5				
Cat 3&4							
%	14.2	16.0	16.8	13.0	17.5	21.5	16.6
RGH	**188**	**173**	**180**	**166**	**148**	**149**	**166**
CS Rate							
%	28.7	33.5	28.9	24.1	**42.1**	**41.1**	31.3
Cat 1&2							
%	13.3	14.1	12.8	10.8	17.9	13.7	10.4
Cat 3&4							
%	15.5	19.4	16.1	13.3	24.1	27.4	20.9
PCH	**129**	**133**	39	**126**	**143**	**129**	**143**
CS Rate							
%	33.9	31.8	31.7	28.5	33.1	31.5	35.2
Cat 1&2							
%	18.9	16.7	9.8	13.0	18.0	10.2	18.3
Cat 3&4							
%	15.0	15.2	22.0	15.4	15.1	21.3	24.0

Induction of labour

The IOL rate continues to be above the 20% target and the rate for the past 4 months is demonstrated in the table below.

IOL %	Jan	Feb	March	April
Total Births	**335**	**335**	335	316
HB IOL	38.2%	37.7%	32.7%	37.1%
RGH				
IOL rate	**39.8%**	**40.0%**	**36.6%**	42.8%.
PCH				
IOL rate	**42.5%**	**43.2%**	35.6%	37.4%

The Directorate Induction of Labour audit has been completed and the results were shared in the audit meetings. The findings of the audit were similar on both sites and identified that some IOL procedures were performed outside of NICE recommendations and many women did not have a membrane sweep as recommended by NICE guidance.

The trends identified from clinical review were that the IOL process is often delayed although the reason is not always clear. NICE Safe Staffing guidance for Maternity Services has a number of Red Flags to monitor and this includes delays in treatment, essentially elective CS and IOL. Efforts continue to Datix report any delay to provide the detail required.

Action

1. A snapshot audit has commenced to :

identify reasons for the delay

gestational age of IOL to be separated 37 / 38 weeks & 39/ 40 weeks and include whether steroids, were required / given

2.Documentation issues

The results of the audit are to be shared with the midwifery teams so the documentation issues can be improved.

3. Poor uptake of membrane sweep

The community midwives have been reminded via team meetings of current best practice in line with NICE guidance. (Offer Primps at 40 and 41 weeks, Multips at 41 weeks)

We have now secured a link with the 'Remembering my baby' photography charity through Claire Price, one of the local photographers.

'Remember My Baby' is a UK based registered charity which offers a gift of baby remembrance photography to all parents experiencing the loss of their baby before, during or shortly after birth.

At Prince Charles and Royal Glamorgan Hospitals bereaved parents of babies 24 weeks gestation and above, will be offered the opportunity to have professional photographs taken of their baby, subject to a local photographer being available to take the photo's.

I will liaise with the midwives/Band 7's and make arrangements for a photographer to attend the hospital (subject to availability). The photographers will only take photos of the babies if accompanied by the parents/midwife. Parents are required to complete and sign a consent form requested by the photographer, of which we will have a copy to place in the woman's notes. A digital retouching team will then edit the images taken so that they can be delivered to parents inside the 4-6 week timescale that they quote for the finished images.

By law the photographers are not required to have a DBS check, however Claire informs me that they have a letter from the DBS which allows them to attend the hospitals to take the photographs. I have asked her to forward me a copy of the letter for us to keep on file.

Directorate Quality & Safety meeting (Q&S)

The Directorate remains committed to the delivery of high quality services and strives to continually improve quality, safety and the all-round patient experience, protecting and improving health and maintaining services which are accessible and sustainable ensuring all services are patient centred and driven by their needs, all delivered in an open and honest manner and for all professionals to lead by example. The O&G Directorate monitors quality assurance through the quarterly Quality & Safety meeting which is chaired by the Clinical Director /Head of Midwifery, Gynaecology & Sexual Health and reports to the Health Board Quality & Safety Committee.

The Directorate Maternity Dashboard monitors performance against agreed standards/targets and reviews and measures progress from the preceding month's dashboard. Performance is monitored alongside the agreed targets with monthly SBAR reports produced for the Director of Nursing & Midwifery for assurance and monitoring purposes with the monthly red alerts highlighted and clear actions demonstrated.

Datix reporting remains robust within the Directorate and in the recent quarter there was an 8% decrease in reporting. All Datix incidents have a clinical review and further investigation and actions are taken when appropriate/indicated . All incidents continue to be reviewed weekly by the Head of Midwifery and Senior Midwife with a multiprofessional review team examining each case in more detail weekly, in addition to a Supervisor of Midwives overview.

Admission/discharge & transfer is the highest reporting category. The total number of inutero transfers from March – May 2016 were 21.

7 pregnancies were < 28 weeks gestation

7 pregnancies were 31 – 34 weeks gestation.

7 pregnancies was > 34 weeks gestation (34 weeks 6 days gestation).

The reasons for transfer were:

Possible premature labour.

NNU unable to accommodate due to staff or activity within the NNU.

8 inutero transfers were to Maternity units outside Wales. The transfers were to Wolverhampton, Birmingham, Bristol and Gloucester. There were no poor outcomes and no concerns have been identified.

Incidental learning from reviews**.**

Following a review of records it has been noted that the symphysis fundal height (SFH) is not always plotted on the individualised growth chart as required. An All Wales training session with the GAP team from the Perinatal Institute has been arranged for the 9 & 10 June and obstetric, midwifery and sonography leads have been nominated to attend. This should improve care and compliance with the GAP protocol in support of improved detection of SGA babies – who are at increased risk of stillbirth

Claims

During the period 1 January-31 March 2016 the Health Board received notice of the following Claims for Obstetrics, Gynaecology & Sexual Health:

No new personal injury cases

No new redress cases

No new inquests

3 New Clinical Negligence Cases

Claims - Closed

During the period the Health Board closed 1 Clinical Negligence Claim (tubal ligation). Breach of duty of care and causation of harm were admitted.

Complaints

During the period 1 October to 31 December 2015, 6 formal complaints were received relating to the Directorate, a reduction of 2 from the previous quarter. Trends are related to failure to provide care, staff attitude and communication breakdown.

Risk Register

The risks on the register were discussed in the recent Quality & Safety Meeting. The risk ` No dedicated 2nd Obstetric theatre ` was reduced to a green status. This risk is well managed and no concerns / issues have been received.

A new risk has been added to the Risk Register` Issue of obstetric staffing, linked to the allocation of trainees from the Deanery in order to maintain services on both sites`.

Kirkup Report

Quarterly multidisciplinary meetings are in place to review and update the action plan. The recent

meeting showed good attendance from all specialities and much progress added to the action plan. The action plan is currently being updated and will be shared with all professionals when complete. A future date has been arranged for September 2016.

Maternity Network

All Wales Dashboard.

An All Wales Maternity Dashboard has been agreed with data received from all HB`s within Wales. This will be useful to benchmark HB` performance against other units.

Sepsis

Recent workshop identified variations in care across Wales. An All Wales sepsis guideline will be developed following the publication of the NICE guidelines which is to be distributed in August 2016.

Altered Fetal Movement All Wales guideline

This guideline has been agreed by professional throughout Wales and will be distributed shortly.

Pathology Perinatal Group

The name has been changed to Bereavement Group as this will address standardisation of bereavement care in view of the new Drivers. There is an All Wales post mortem consent audit tool based on the All Wales post mortem standards. All Wales data is collected on a monthly basis and the data will be used to benchmark standards against other units.

MBRRACE report (2014 births).

This report was published in May 2016 and indicated the stillbirth rate within Wales to have increased. Intrapartum stillbirths in Wales 0.68 / 1000 births. UK – 0.3/ 1000 births. CTUHB has been identified as having a higher than average stillbirth rate (4.8%. Wales 4.1%). There is a need for local review of all cases from 2014 to identify any common trends. Multiprofessional review groups are to meet from June 2016. Cases from the sister site will be reviewed (RGH review PCH cases and visa versa) in the form of an independent external review to avoid bias and ensure learning across both sites. **All Wales Maternity Strategy**

The All Wales Maternity Strategy Performance Indicators have been reviewed and each Health Board has fed back to NWIS. The annual Autumn Maternity Performance Board Welsh Government meeting is to be held on 18th October 2016 to feedback the CTUHB position.

CTUHB Perinatal Mental Health Services

The new service was launch in May 2016 and includes the appointment of a Band 7 Perinatal Mental Health Specialist Midwife. The first task is to scope and map current services, hold multi-professional agency workshops to feed into guideline and pathway and to commence a CTUHB perinatal mental health forum

Maternity Information Technology System (MITS).

There have been some initial difficulties with case viewer but these have now been rectified. The system has been rolled out within the Community Midwifery teams as a priority as there is a WG requirement for the 36 weeks gestation data (BMI) to be inputted into the system.

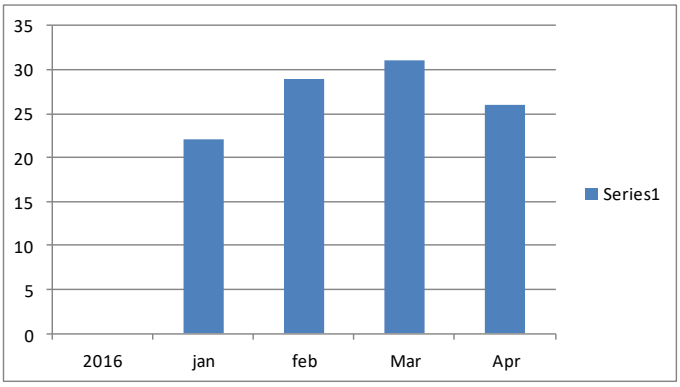
The third version of the All Wales Hand Held Maternity records was introduced June 2016. A Task & Finish Group is to meet on June 13 2016 to agree guidance to support accurate completion of the notes and the introduction of new sections e.g. Risk assessment sections.

Qlik sense

This is an electronic application which is accessed via Sharepoint to provide daily maternity data activity reports. The programme has been introduced to provide an up to date overview of the maternity statistics obtained from MITS. There are many streams of data available to professionals to produce

reports and information relating to maternity statistics.

Tair Afon Birth Centre (TABC)
TABC births continue to increase The table below indicates the 2016 births.



On 9 th May 2016 an alongside birth centre (AMU) in RGH known as Tirion Birth centre opened its doors to low risk women. This has a birth pool and capacity for 2 women to labour at any one time.

Breast feeding
In preparation for the BFI assessment there is a focus on the standards that need improvement. Recent local audits have demonstrated an improvement but a continued need for ongoing staff awareness and training.

Audit Guidelines
Outdated guidelines have been highlighted by Welsh Risk Pool and this is monitored on the Directorate risk register. National guidelines have been reviewed to ensure outdated guidelines are not a risk to women. No major changes have taken place. The number of guidelines now in date continues to increase to over 40%.
The following guidelines were ratified by the group.

- Anti D
- Breech Presentation
- Retained Placenta
- Female Intimate Examination
- Handover of Labour Ward
- Telephone Triage
- Transitional Care
- Uterine Rupture
- Antenatal Care
- Obesity
- Shoulder Dystocia
- Record Keeping
- Admitting Pregnant Women to A+E

Staff are informed of new information contained within the guidelines and teaching sessions undertaken at every opportunity. E mails are sent to professionals informing them of the changes and review and notice is placed on the Safety Briefing and Risk Newsletter.

Gynaecology
Out Patient Hysteroscopy clinics now operate on both sites and the final decision from the Clinical Director is awaited with regards to the Outpatient Hysteroscopy Protocol. The intention is to share the referral pathway for Outpatient procedure with Primary Care in South Cwm Taf. The training for a

Nurse Hysteroscopist has been completed and it is hoped to receive approval for extra staffing shortly to secure extra clinics.

Following a service review, the decision was made to withdraw IUI services from Cwm Taf UHB due to the very small numbers of cases being managed.

Sexual Health
No decision has been made to the appointment of Consultant Community Gynaecologist and this is on the Directorate Management team agenda.
Approval for the implementation of Electronic Patient records via Blithe Lillie system is to commence as soon as equipment and templates are received. Two sites are to be piloted prior to roll out of the programme.
There is a proposal to relocate GUM services from Royal Glamorgan Hospital to Dewi Sant. Discussions are ongoing and a project board has been set up with HR and staff side involvement
Psychosexual counselling service have commenced in December 2015, utilising internal expertise and resource.

ACHIEVEMENTS

Positive feedback from women and their families from Tair Afon and Tirion Birth Centre.

Continued increase in births on the Tair Afon Birth Centre.

Launch of Perinatal mental health services in May 2016.

Key risks and issues / matters of concerns and nay mitigating actions

Gynaecology
Deskilling of staff due to proposals to decrease fertility services
Possible unacceptable waiting times for clients
Delay in appointing Gynae patients into OP appointments. Risk of potential waiting list breach.

Obstetrics
Increase in the number of vacancies within the Directorate caused by staff leaving and failure to recruit at all grades (medical, nursing/midwifery and administrative) due to the uncertainty of the service direction.

Resultant high demand on locum doctors and limited midwifery bank availability of varying clinical experience.

Matters requiring Board/Committee level consideration and/or approval

None

Matters referred to other Committees

None

Minutes submitted (insert √)

Date of next meeting