AGENDA ITEM
2.15

CTM BOARD

UPDATE ON MATERNITY SERVICES IMPROVEMENT

Date of meeting	12/05/2020
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Val Wilson Director of Midwifery, Gynaecology and Integrated Sexual Health
Presented by	Val Wilson Director of Midwifery, Gynaecology and Integrated Sexual Health
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Maternity Improvement Board	12/05/2020	NOTED
Quality & Safety Committee	12/05/2020	NOTED
Management Board	20/05/2020	NOTED

ACRONYMS	
IMSOP	Independent Maternity Services Oversight Panel

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide the Board with an update on Maternity Services. An update on actions taken and the known related implications of the special measures arrangements to date is summarised in this report.

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

2.1 The Board is asked to consider the Highlight Reports for the individual projects in the Maternity Improvement Programme (appendices 1-4).

2.2 The Highlight Reports include metrics that continue to be further refined. Robust reporting continues to be challenging due to different systems across the Cwm Taf Morgannwg area. Currently, our information analyst gathers, collates and rationalises information from both systems in order to produce comparable data for the service. Work has begun to produce a service wide 'click-sense' report which will partially mitigate the risk until the All Wales maternity IT solution is agreed and implemented. Further discussions are planned to identify what further actions can be undertaken to strengthen current mitigations.

2.3 The Highlight Reports have been updated following the Independent Maternity Oversight Panel 'Collaborative Check-In Visits' on 18 February 2020. These evidence the recommendations that the Independent Maternity Oversight Panel regard as completed.

2.4 The 'Collaborative Check-In Visits' on the 18 February 2020 verified 41 of the 79 report recommendations.

On-going progress noted in other areas include:

I. The development of a draft Maternity Vision which is currently out for internal consultation initially and will be published in August 2020 as planned to coincide with workforce changes. This period prior to publication will be used to consult widely with both internal and external stakeholders.

II. Three successful engagement events have been held, two in November 2019 and one in February 2020. All of which were well attended, highlighting the positive experiences of women and families and also areas where further targeted improvement work

is required. Feedback from all three engagement events has been analysed and used in conjunction with the recommendations to form the development of a draft "Three Year Maternity Engagement Plan".

III. The Maternity Improvement Team are part of a collaborative "valued based healthcare" project with Aneurin Bevan and Doctor Doctor. The aim is to measure individual experiences of maternity services in the form of a Patient Reported Experience Measure (PREM). A draft PREM has been developed and is in the process of being quality assured by Doctor Doctor. The PREM will be a sensitive measure which incorporates a long term approach to capturing feedback across the maternity care pathway.

2.5 The Independent Clinical Reviews are progressing with the Health Board's Lead Midwife working closely with the Independent Maternity Service Panel Clinical Reviewers to ensure that processes are managed effectively and plans are developed for any learning to impact on future care.

Clinical Review Progress

All 27 maternal morbidity cases have been uploaded. Ten cases have currently been reviewed. Five cases have been quality assured. The Health Board will be receiving this feedback shortly.

There are currently six teams of reviewers, aiming to complete 6-8 cases each month.

Self-Referrals

To date there are 42 self-referrals. These consist of women who have contacted the previous helplines, through complaints channels outside of the Putting Things Right (PTR) timeframe or those who have attended engagement events. This number was initially higher, however, these have been managed as debriefs and closed by the Consultant Midwife. This work has been undertaken with the oversight and agreement of the Panel.

The self-referral cases range from 1991-2017.

To date 18 women have been contacted and have disclosed their concerns surrounding their maternity care.

Each individual case is discussed with IMSOP leads fortnightly to discuss recommendations put forward by the Health Board on how best to manage each case.

No open at end of last month	52
Cases for triage	42
Number of cases triaged	18
Cases closed at triage in month	10 (debriefs already completed by MD and closed)
Total Number of Cases Open at Month End	42

2.6 The Independent Maternity Services Oversight Panel's Spring Progress Report was published on 30 April 2020 (appendix 5) and reported that the Health Board has made **good progress** during January, February and March and as a result, the Panel believes that the Health Board is now **firmly on track**, not only to deliver against the Royal Colleges' recommendations, but also, in time, to deliver a maternity service which they, their staff and their communities can be proud of.

During the period under review, the Panel has assessed evidence which provides them with reasonable assurance that a further 16 recommendations have been delivered since they last reported, bringing the total now completed to 41 which means that the Health Board has now delivered over half of the 79 recommendations in the Maternity Improvement Plan with the remainder work in progress. The themes in focus during the next period include the development of our engagement plans and the development of a governance and assurance framework and the further development of work relating to the neonatal service. We will also be working with the oversight panel to evaluate and plan how, in time, we will move the service further through its improvement journey. This will initially be moving from a project managed approach to a service-led approach and that will in due course move us closer to being able to develop an exit strategy.

2.7 Concerns and Complaints

There are currently 18 open formal complaints in the directorate. 31 complaints have been closed during March and April 2020. The team are now undertaking a retrospective thematic review to ensure the opportunities for learning and improvement have been maximised. This will continue on a monthly basis going forward.

2.8 Serious Untoward Incidents

Within the health board process, there are 22 serious incidents (SI)'s currently under investigation within the directorate. A reconciliation piece of work is currently underway of SI's in backlog and awaiting closure reports and those SI's linked to a redress or a claim.

The team will then move forward to undertake a deep dive into open action plans and thematic reporting to ensure all actions have been completed and that themes have been identified and addressed.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 There are a number of pending changes to the Maternity Improvement Programme workforce. The previous Maternity Improvement Director has been successful in securing a Locality Nurse Director post in the new locality structures, she commenced this in April 2020. The Director of Midwifery will now oversee the continued improvements in the service and is currently developing plans to ensure that there is a managed transition and that there is limited impact on the programme delivery. These plans will be subject to ongoing consultation with both the Panel and Welsh Government

3.2 The Health Board is implementing a new Operating Model from 1 April 2020 that transitions services into three localities. A proposal to delay the transition of Maternity Services to the locality model has been agreed in order to further embed improvements within the service prior to the change.

4. IMPACT ASSESSMENT

The true impact assessment cannot be articulated at this stage whilst the Director of Midwifery transitions into the new model having taken up the Director of Improvement position.

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Choose an item.
	If more than one Healthcare Standard applies please list below: Safe Care Dignified Care Effective Care Individual Care
Equality impact assessment completed	No (Include further detail below)

Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	The Improvement/Project Team workforce capacity for the achievement of the recommendations has been utilised to support the Clinical Review Strategy. This has implications on the timely implementation of all recommendations.
Link to Main Strategic Objective	To Improve Quality, Safety & Patient Experience
Link to Main WBFG Act Objective	Provide high quality care as locally as possible wherever it is safe and sustainable

5. RECOMMENDATION

5.1 The Board is asked to **NOTE** this report.