



AGENDA ITEM

4.1

CTM BOARD

MATERNITY AND NEONATAL SERVICES UPDATE

Date of meeting	16/03/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Jane O’Kane, Systems Director preconception to 1000 days & Neonatal Service Improvement Director Val Wilson, Director of Midwifery, Gynaecology and Integrated Sexual Health, Maternity Services Improvement Director
Presented by	Jane O’Kane, Systems Director preconception to 1000 days & Neonatal Service Improvement Director Val Wilson, Director of Midwifery, Gynaecology and Integrated Sexual Health Maternity Services Improvement Director
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	Date	Outcome
Quality & Safety Committee	16/03/2021	Choose an item.

ACRONYMS	
NNU	Neonatal Unit
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital

POW RCOG IMSOP SIs PMRT	Princess of Wales Hospital Royal College of Gynecologists Independent Maternity Oversight Panel Serious Incidents Perinatal Mortality Review Tool
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1. SITUATION/BACKGROUND

- 1.1 This paper provides a position update with regard to the IMSOP review and associated improvement relating to Health Board Maternity services and Neonatal services. This is in the context of the RCOG review of Health Board Maternity services (January 2019) and with the IMSOP programme of work extending to formally include NNU services in 2020

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

2.1 Neonatal Improvement Team recruitment

Consultant Neonatology sessions have been secured from neighboring tertiary centres to support both sites equating with greater medical leadership, focus upon aspects of governance and innovation. A number of nursing posts are being recruited to currently to ensure adequate leadership and capacity within both the clinical review element and quality improvement component. Appendix 1 and appendix 2 demonstrates the structures and associated responsibilities

2.2 Neonatal Quarterly Achievements

2.2.1

9 of the 16 RCOG Neonatal recommendations that are being monitored by IMSOP were submitted with evidence for their review in February. In principle the same were received positively but a formal review of the same was delayed for 4 weeks at IMSOP request; to allow newly recruited Neonatal IMSOP members to participate in the same once Welsh Government (WG) confirm the appointments.

2.2.2

Clinical reviews (PMRTs) are now well established across the Health Board and the lessons learnt are being progressed and shared through a refreshed Neonatal Forum.

2.2.3

Positive proactive collaboration with Maternity services in developing shared governance arrangements has equated with a range of revised clinical governance meetings with Neonatal and Maternity membership.

2.2.4

Policy development has progressed at pace through a Multi-Disciplinary Team (MDT) approach to ensure all Neonatal Health Board policies are current. The approach for dissemination is being progressed.

2.2.5

An initial framework of staff support and engagement has been developed and is being implemented to support staff as IMSOP activity progresses. This incorporates a range of activity from monthly Question & Answer sessions chaired by the Medical Director to bespoke 121 sessions with staff as requested, access to Well Being services and the Multi faith Chaplain.

In collaboration with the Workforce and Organisational Development (OD) team, there will be additional support to align with the Maternity services approach and ensure that there is dedicated support for teams as the reviews into still births and neonatal deaths progresses.

2.3 Maternity Services

2.3.1

The service has completed 50 out of 70 recommendations

The Maternity Improvement Team (MIT) have continued to collate evidence of completion of recommendations. Despite Covid challenges, a further 9 recommendations were submitted for consideration in February. 2 were agreed as completed, 4 required further evidence (3 of which should be possible within the timeframe). The service was advised at the evidence review meeting that the panel required evidence for the remaining 3 that would not be possible to achieve in the timeframe (a new scanner to arrive, evidence of large scale engagement, Panel to undertake triangulation exercise in respect of board assurance).

2.3.2

We continue to receive reviews from the stillbirth category. Actions are developed to address and failings or learning and an action plan developed with a multi-disciplinary team (MDT). Evidence of any completed actions is compiled and considered by the MDT Clinical Cabinet to ensure a robust response. The Panel plan to begin writing to families in small batches during March, and the stillbirth thematic review is planned for early summer.

2.3.3

The MIT have worked with work stream leads to undertake a review and 'refresh' of the remaining recommendations (appendix 3) and there are staff meetings in place to consider how we move forward post the current covid wave.

2.3.4

An MIT project officer has recently secured a permanent role and interviews for a replacement is planned for w/c 15.03.2021. The Lead Midwife begins maternity leave on the 15 March and her replacement commences in role on the 1 March. The support of a Programme Director will also be sought to support programme management and enable capacity for the Neonatal and Maternity Improvement Directors.

2.3.5

Maternity Services Serious Incident Backlog

The service has now completed 10 from the backlog of 43 (previously 44, 1 case now downgraded). Unfortunately, covid has had a massive impact on the availability of staff to undertake investigations. The Health Board have supported the service with the procurement of 2 external interim investigators, and a Senior Midwife (former Head of Midwifery) to support quality assurance to ensure on-going 'fresh-eyes'.

2.3.6

The review of Maternity Service at the Shrewsbury and Telford NHS Trust (Ockenden Report) was published in December 2020 which reports on the first 250 reviews of the 1,862 cases under consideration.

A number of themes have been identified (27 local and 7 for national consideration). The service has undertaken a detailed benchmarking exercise of both local and national actions. We are also working collegiately will other maternity leaders to consider the findings across Wales.

There were 30 actions for maternity services and 4 for neonatal services (1 of these is a joint Neonatal/Maternity action). It is encouraging that the service already had either completed or on going actions for the themes identified in the Ockenden report and there were no issues that had not previously been identified within the improvement work.

Service	Green Results in most areas with clear plans for delivery on all aspects	Amber Plans already in place with new actions to strengthen	Red Issue not previously identified
Local Actions			
Neonatal	2	2 Specific activity progressing re: 1)NN records/record keeping 2)ANNP rota adjustments with Tertiary Unit	
Maternity	15	8	0
National Actions			
Maternity	3	4	0



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

3.1 The following summarises some of the key areas of work that are now being progressed

- The development of key neonatal performance indicators is being progressed in a Neonatal workshop early March aiming to agree the same by April to feed into the IPAFF
- A Neonatal family engagement strategy is being developed to incorporate both preventative support and guidance for families post discharge as well as a programme of support linked to the clinical review outcomes
- Quality Improvement (QI) methodology is proposed to support the required innovations with a small QI team trained on each site
- The Maternity PREM will go live in April
- Leadership development for new teams in the Women's and Children's Directorate is currently being scoped in house
- The Health Board Strategic Lead for Wellbeing is now working with Maternity Services to develop a confidential survey considering issues such as working relationships, cultural issues, how change happens, how information is communicated.

3.2 It should be noted that there has been a subsequent MBRRACE report: *Stillbirths and Neonatal Deaths in Twin Pregnancies 2020*. Maternity services and Neonatal services are currently reviewing the data and will provide a subsequent report to the next Quality & Safety Committee.



4. IMPACT ASSESSMENT

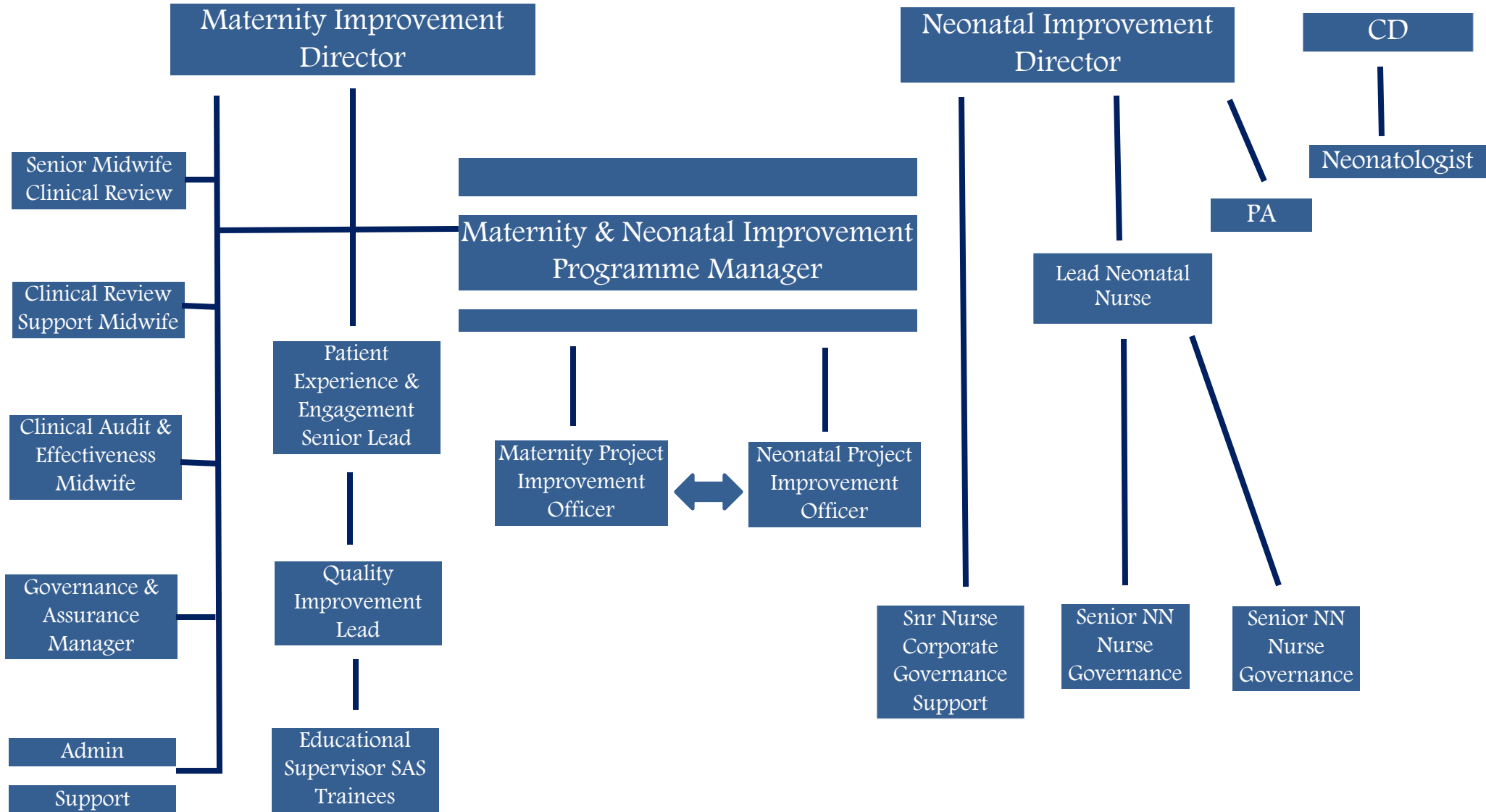
Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below: Safe care Effective care Timey care Dignified care
Equality impact assessment completed	Not required
Legal implications / impact	Yes (Include further detail below) Pending advice from the Coroner
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below) See details of revenue within the body of the report
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 That the Board **NOTE** the content of this report and the progress made in relation to the Ockenden Report and the current Health Board reviews.

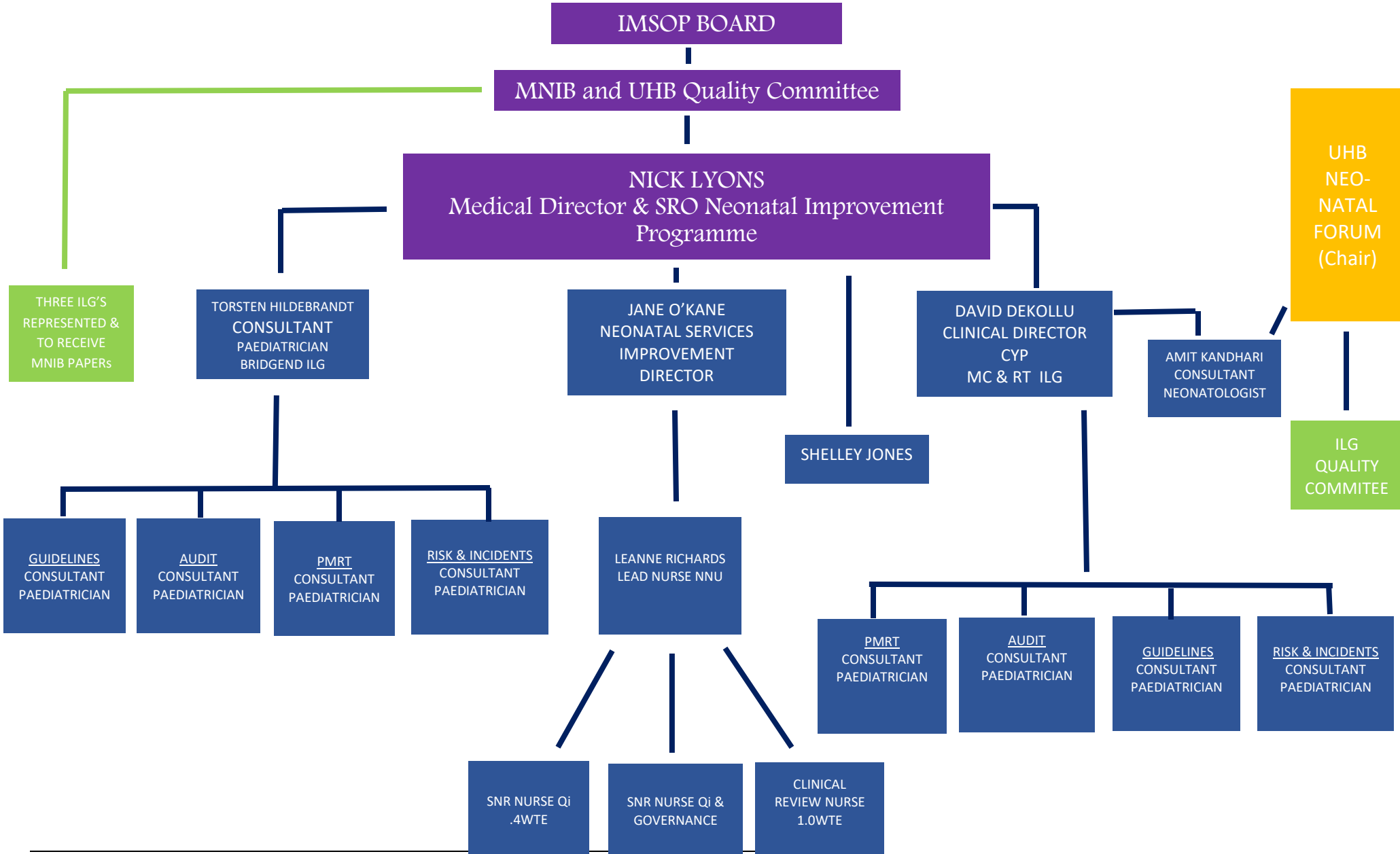


APPENDIX ONE





APPENDIX TWO



Maternity Services Improvements Reflect to underpin Refresh

February 2021

Quality, Leadership & Management Update

Recommendations Signed off

7.05	CTG training programme
7.06	Induction for Medical Staff
7.13	Clinical Lead for Governance
7.15	Educate staff on importance of risk management
7.18	Methods of consultant working
7.22	Outcomes of Serious Incidents
7.24	Clinical lead to support midwifery governance lead
7.25	Consultant & Nursing Lead for Clinical Audit/Quality Improvement
7.28	Executive lead for midwifery
7.29	Staffing
7.30	Medical director has effective oversight & management of consultant body
7.32	Obstetric consultant cover
7.33	Share findings with Welsh Deanery
7.34	Clinical and educational supervisor for all trainees
7.37	MDT teaching programme
7.40	Extended practice roles
7.41	Culture considerations following merger
7.43	Future Improvement



7.46	Clinical Lead Roles
7.57	Recruit and retain permanent staff
7.58	Expert external midwifery support & ways of working
7.62	Investigation of lack of action by Exec Team & Board
7.64	Independent Board members training
7.68	Examine other UK Maternity services

Recommendations Remaining

7.8	Ensure external expert facilitation to allow a full review of working practice to ensure: <ul style="list-style-type: none">• patient safety is considered at all stages of service delivery,• a full review of roles and responsibilities within the obstetric team,• the development and implementation of guidelines• an appropriately trained and supported system for clinical leadership,• a long term plan and strategy for the service• There is a programme of cultural development to allow true multi-disciplinary working.
7.17	Ensure training is provided for all SAS staff to ensure they are: <ul style="list-style-type: none">• up to date with clinical competencies• skilled in covering high risk antenatal clinics and out-patient sessions
7.35	Undertake a training needs assessment for all staff to identify skills gaps and target additional training.
7.39	Review the working practice for how consultant cover for gynaecology services will be delivered after the merger.



	<ul style="list-style-type: none">• a risk assessment must be performed to determine the case mix of planned surgery on the Royal Glamorgan site when there is no resident gynaecology cover.
7.42	<p>In conjunction with Organisation Development undertake work with all grades of staff around communication, mutual respect and professional behaviours.</p> <ul style="list-style-type: none">• staff must be held to account for poor behaviours and understand how this impacts on women's safety and outcomes
7.44	<p>Support training in clinical leadership.</p> <ul style="list-style-type: none">• The Health Board must allow adequate time and support for clinical leadership to function
7.45	<p>Provide mentorship and support to the Clinical Director</p> <ul style="list-style-type: none">• define the responsibilities of this role,• ensure there are measurable performance indicators,• ensure informed HR advice to consistently manage colleagues' absence and deployment of staff to cover the needs of the service,• Consider buddying with a Clinical Director from a neighboring Health Board
7.56	<p>Provide training for staff in communications skills, in particular on:</p> <ul style="list-style-type: none">• Empathy, compassion and kindness.
7.69	<p>Identify and nurture the local leadership talent.</p>

Quality, Leadership & Management Update February 21

Within the Quality, Leadership and Management (QLM) work stream, 24 recommendations have been verified by the Independent Maternity Services Oversight Panel (IMSOP) to date relating to training, workforce, leadership and educational support.

A lot has happened in the past year and so members of the Quality Leadership and Management group have met to take stock on where we are and to reassess where we are heading. This has been a useful exercise to allow focused time on the journey we have been on since the RCOG report was published in early 2019.

Journey so far

- Maternity Services are now on two sites – Prince Charles Hospital and Princess of Wales Hospital.
- Midwifery led unit is based at the Royal Glamorgan Hospital
- Director of Midwifery, Gynae and ISH in post with two Locality Heads of Midwifery, Gynae and ISH appointed 19.2.21
- 24 recommendations completed
- 9 remaining recommendations to complete – majority of the 9 are the longer term actions that take time to work through and involve meeting staff face to face
- Leadership Programme for Consultants, Senior Midwifery Team and Band 7's has been completed through Covid and feedback has been very positive.
- A lot of progress has been made but we know there is still a lot to be done and with the impact of Covid we are not as far along as we would want to be, however we need to recognise the long term nature of the ask and to address cultural improvement will take concerted time and effort. The directorate has fully embraced the approach to support learning and improvement across all staff and has programmes established and progressing.
- Engagement of clinicians has markedly increased with plans to continue group sessions with clinicians across the Health Board.

Next Steps

- Reviewing what's gone well during covid – team building, solidarity and supporting one another
- Senior Leadership Team Engagement to lead the projects - 2 meetings have already taken place

- Staff Wellbeing – Organisational Health Review (OHR) supported by Head of Wellbeing. 2 meetings have taken place – the Head of Wellbeing will now begin preliminary comms with staff
- Values and Behaviours work based on outcomes of the OHR supported by Head of OD. 3 meetings, emails made to introduce Head of OD to new in-coming ILG teams and Maternity team. Head of OD will begin scoping work with the teams for next stage team development/team building
- Face to face multi-disciplinary training for all staff at all levels in Maternity Services on compassionate care
- New management development programmes (developed in house) ready to roll out to staff from new financial year.
- Deputy Head of WF & OD leaving but plans in place for support
- Mandatory training – work ongoing through the Senior Leadership team to review and address with clinical and non-clinical teams to support teams to have protected time to complete e-learning and mandatory training.
- Training - in line with our plans for our long term strategy, there are established training programmes for senior clinical colleagues with work ongoing to establish an annual training programme for all staff.
- PDR compliance - the directorate has achieved an improved position, however a large proportion of staff are without a PDR. The Senior Team are working to address to ensure that all staff have an up to date PDR.
- Senior midwife recruited to underpin short scoping project to understand wider staff development (Midwives and HSW) – beyond statutory and mandatory training
- Development of a plan to address several areas:
 - How we identify and support leaders within the directorate.
 - How we embed Health Board values and expected behaviours, supporting staff as appropriate.
 - Establish rolling programme of leadership, culture, values and behaviours training on annual basis for all staff.
 - Provide supportive environment that will address individuals training, physical and emotional needs and provide safe space for staff to speak up.
 - Ensure an effective approach (Health Foundation information) is embedded in our approach so that staff have autonomy, sense of belonging and contribution.
 - Ensuring workforce development, Values and Behaviours are embedded in our TNA alongside clinical training.

QWE Recommendations Signed off

7.47	Develop MMMW (MSLC) as a hub for women & families
7.48	Utilise role of Community health council
7.49	Engagement with women & families



7.50	Build on community based engagement (MSLC)
7.52	Experience of women & families effected by events
7.55	Bereavement Service

Recommendations Remaining

7.53	<p>Review the communications, support and engagement approach and strategy.</p> <ul style="list-style-type: none">• Ensure that the focus is not solely on management of key messages• Demonstrate openness, honesty and transparency, admission of fault and learning from this
7.54	<p>Prioritise an engagement programme with families at its heart.</p> <p>Women and families affected by events should be part of the improvement, co-design and culture change of the new service</p>
7.67	<p>Develop a strategic vision for the maternity service and use the current opportunity of change to create a modern service which is responsive to the women and their families and the staff who provide care.</p>
7.70	<p>Ensure that any future service change for the development process of the maternity service as a whole is inclusive for all staff and service users.</p> <ul style="list-style-type: none">• Ensure the service is adequately staffed to ensure that all staff groups are able to participate in developing the vision• Consider an externally facilitated and supported process for review.

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| | <ul style="list-style-type: none"> Consider seeking continued support from Healthcare Inspectorate Wales (HIW) and the Royal Colleges to undertake a diagnostic review of the service particularly in relation to changes in service provisions. |
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Quality Women's Experience Update February 2021

Within the Quality Women's Experience work stream, 6 recommendations have been verified by the Independent Maternity Services Oversight Panel (IMSOP) to date relating to developing the MMMW to act as a hub for women and families, building on community based engagements. The service continues to work closely with the Community Health Council. The Service has prioritised the engagement activity it undertakes to support engagement and feedback opportunities for women and families which is now fundamental to all quality improvement work undertaken within the service.

During 2020, despite Covid, engagement has continued as a priority, and we have used creative ways to enable engagement and feedback to continue despite significant changes to the way we would usually engage with women, families and the community.

- We have grown the number of active attendees in MMMW, and have prioritised regular meetings throughout 2020 and into 2021
- MMMW have representation throughout the service, in different fora, assurance meetings, the Maternity Improvement Board and Wales wide at Maternity Services Improvement Board.
- We have obtained a significant volume of engagement via maternity services social media (Maternity services page and Bump Talk group)
- We have used creative ways e.g. interactive polls via social media, to optimise engagement and feedback around specific issues which have been identified
- We have co-produced virtual tours of the clinical environments to support women with choice
- We have produced a monthly infographic which gives women, families and the community some valuable insight in to maternity services activity and offering a celebration for families around the birth of their baby. This has been positively received by women, families and the community and created a significant volume of positive engagement
- We have produced several videos e.g. water birth, and Baby Loss Awareness Week, which have obtained a significant volume of engagement
- We have implemented Women's experience boards across the service which allow us to display service user experience data
- Introduced the use of women's stories at meetings and in training to allow learning and reflection from the 'lived' experience of women

- Developed a comprehensive Engagement Plan, which outlines the commitment of the service to the implementation of a wide ranging engagement programme

Next steps

- Recruitment of Patient Engagement Lead
- Continue work to advertise and encourage participation and growth of MMMW, including engaging with hard to reach groups and community representatives
- Continue commitment to co-produce service user friendly information resources across the pregnancy journey with MMMW in response to feedback obtained
- Ensure we continue to capture meaningful Patient Advice Liaison Service (PALS) information across all sites
- Develop and expand the women's experience champion roles within the service
- Develop a 'Speak up for Safety' campaign to engage women and families in early identification of safety concerns or issues.
- Develop a Maternity Patient Reported Experience Measure (PREM) – draft out to consultation
- Develop a 'de-briefing' pathway to ensure all women who require discussion or explanations about their care receive this, in response to feedback obtained
- Continue to use women's experience data to prioritise training and learning which is focused on those issues most important to women
- Work currently underway to develop large-scale virtual engagement events to engage women, families and the community in developing the CTM response to the All Wales Maternity Vision, and how we prioritise improvement work to respond to local needs and priorities
- Detail more fully how future engagement with external stakeholders, reports and recommendations e.g. HIW/CHC are used by the service to identify new quality improvement actions and taken forward via the live Maternity Improvement Plan
- Prioritise work around partner engagement and partner inclusion
- Prioritise work around improving infant feeding service in response to feedback obtained.
- Baby Friendly accreditation on Prince Charles Hospital (PCH) site
- Consider 'customer care' training for midwifery staff, to assist in early resolution and 'on the spot' concerns
- Improve standardised reporting around all areas of patient experience to clearly demonstrate learning and impact on service development – Women's and Families forum to remain as part of the governance re-structure as we move into Integrated Locality Group (ILG) structure.
- Launch staff intranet website



- Update and improve maternity services front facing web page
- Develop a care pathway to optimise communication, emotional care and bonding for women admitted to Intensive Treatment Unit (ITU) during pregnancy/childbirth
- Develop memory boxes for mothers whose baby may be looked after in a foster care placement
- Develop continuity pathways for women during pregnancy (particularly those with additional need e.g. perinatal mental health/multiple vulnerabilities)
- Improve patient experience feedback data capture and recording (Civica, Qlik Sense App)
- Develop an interactive information resource for service users (to include video tours, video presentations, leaflets and signposting to external websites and resources) in response to feedback obtained.
- Prioritise specific and sensitive engagement around early pregnancy loss to capture service user feedback to implement improvements and develop early loss services
- Legacy Events - Develop a plan for memorial and remembrance activities to align with Baby Loss Awareness Week with specific emphasis on CTM always remembering the past and where we have come from
- Develop birth trauma awareness work, training and reflection



Safe & Effective Care:

Recommendations Signed off

7.02	Guidelines
7.03	Audit
7.04	Monitoring of Clinical Practice
7.09	Trigger list for situations requiring Consultant presence
7.10	Risk Management
7.11	Mandatory attendance at meetings
7.12	Staff debrief
7.14	Consultant Meetings
7.16	Consultant availability
7.21	Improve incident reporting
7.23	Learning from Incidents
7.26	Jointly owned NNU & Maternity services audits
7.27	Governance and risk
7.36	Clinical supervision
7.38	On-call consultant ownership
7.59	Risk assessment for merger
7.60	Effects of reduced inpatient capacity
7.61	Develop plan to increase inpatient capacity if required
7.65	Criteria for opening FMU agreed by MDT group
7.66	Risk register



Recommendations Remaining

7.01	Urgently review systems in place for: <ul style="list-style-type: none">• data collection• clinical validation• checking the accuracy of data used to monitor clinical practice and outcomes• what information is supplied to national audits
7.07	Ensure an environment of privacy and dignity for women undergoing abortion or miscarriage in line with agreed national standards of care.
7.19	Ensure that a system for the identification, grading and investigation of SIs is embedded in practice, through: <ul style="list-style-type: none">• appropriate training to key staff members• making investigations multidisciplinary and including external assessors
7.20	Actively seek to remove the 'blame culture' to allow all staff to develop a willingness to report and learn from SIs.
7.31	Ensure a robust plan of births anticipated in each midwifery led unit and consultant led unit is undertaken <ul style="list-style-type: none">• Ensure involvement of paediatric staff for all future service design reviews and actions
7.51	Ensure responses to complaints and concerns is core to the work being undertaken to improve governance and patient safety: <ul style="list-style-type: none">• Review and enhance staff training on the value of listening to women and families



	<ul style="list-style-type: none"> • Review the process of investigation of concerns, compiling responses, handling ‘on the spot’ issues and ensure that all responses and discussions are informed by comprehensive investigations and accurate notes • Prioritise the key issues that women and families have highlighted to improve the response • Ensure that promises of sharing notes and providing reports to families are delivered • Clarify the process regarding the triangulation of the range of information sources on patient experience, SIs, complaints and concerns and other data and ensure that there is a rigorous approach to make sense of patterns of safety and quality issues • Review the learning from the SIs in relation to misdiagnosis, failure to seek a second opinion and inappropriate patient discharge
7.63	Independent Board members must challenge the quality of the data which informs the reports which they receive and rely upon for assurance

Safe and Effective Care Update February 2021

The service has continued to embed improved governance processes as outlined in the completed recommendations

The guideline group is now well established with good attendance and a clear forward plan. There is good MDT engagement with guideline development and staff are informed of changes. All guidelines are kept on the All Wales portal WISDOM.

Incident reporting continues to flourish and appropriate reporting is evident. During Covid the service has prioritised and remained committed to the incident review process to ensure rapid response to clinical harm. We continue to have effective MDT attendance and engagement.

Methods of learning from incidents has widened to include electronic updates, learning boards, face to face lunch and learn events, MDT Governance Days re-instated (half days currently).

The process and quality of serious incident investigations is improving incrementally with widening clinical engagement underpinned by additional training. Family engagement is improved as is the pace of the response to learning. Covid has impacted on progress on RCA completion and the service has been supported to engage two interim investigators and support to quality assurance to progress this work – in particular the SI backlog. 9 SI's from the backlog have been forwarded for review and the process is now supported by fortnightly meetings with WG.

Complaints management has improved considerably with a large backlog being addressed. Engagement is improving as is the quality of responses. Reporting continues to improve and the management and learning from complaints will be managed in the Women and Families Forum. The forum is being refreshed as part of the alignment to ILG reporting and clear Key Performance Indicators (KPI's) are developed ready for implementation.

Audit is continuing well and this year has seen a more proactive approach to planning and implementing audit. The Health Board is implementing the AMAT platform which will strengthen management and assurance going forward. We have taken the opportunity to include local ward audits and are exploring the potential to add other regular audits (such as BF, ANS etc).

Data quality is improved and we are now able to provide robust service wide and site based reporting via the weekly dashboard and monthly run charts. We continue to work with the Neonatal Maternity Network to develop the All Wales maternity Dashboard.

We have developed timely responses to a number of national and local reports and to the findings of the Ockenden report. We are working with all other services to develop a once for Wales action plan.

MDT working in particular has been enhanced during covid, with rapid responses to ever changing situations evident. MDT handovers are consistently well attended, acuity and escalation now inclusive of medical colleagues. Consultant presence is established and coordinators feel confident in escalation. The senior midwifery on-call process is more closely aligned to the escalation process meaning escalation happens earlier allowing more time for intervention and support. Meetings are more representative of the MDT and joint working with Neonatal colleagues is established in a variety of forums/audits.

Next Steps

- Re-align governance and reporting processes to ILG – we are reviewing all of our processes as we move to a Women and Children's directorate within the ILG structure. We will have developed standardised agendas and KPI's that will demonstrate compliance at service and ILG level. We are currently working with corporate colleagues to standardise data sets for reports. We aim to go live with these in April 2021.

- Women and Children’s Directorates will strengthen joint working and assurance. The overarching Directorate meeting structure has been proposed and service meetings are now aligning prior to a period on consultation and adjustment of Terms of Reference (TOR), Agendas and reporting.
- WESEE meetings have been held informally during the pandemic to support front line leadership and give regular access to the senior team. These will become formalised in April 2021. They will continue to be service wide to ensure consistency of approach and reporting. This will include the production of ‘handover news’ which is a monthly operational update giving staff an insight into Directorate, service and ward information relating to Workforce, Experience, safety and effectiveness.
- Risk register group – the risk register has been largely managed by the senior team. The Health Board has developed a new Risk Management Strategy which will be utilised to support delegated authority to manage the register, and therefore risk more effectively. Operational staff will need support and training to support more local management. There is clear reporting within ILG assurance reporting that the service has already aligned to whilst we have been hosted on one site.
- Further training for both Root Cause Analysis (RCA) and complaints
- Complete RCA backlog
- Complete the LFER backlog
- Improved processes to ensure responsibilities under LFER are discharged at the point of incident/complaint closure
- Data Quality – Digital work stream for maternity services being developed by WG – implementation arm confirmed
- Further enquiry to support reporting and learning – understanding staff views and appreciative enquiry to avoid punitive approaches
- Refresh of learning process to include identification, sharing and impact assessment (aligning to Health Board Learning Group)
- Recruitment of Improvement lead to embed QI at the front line
- Developing more co-production with families in improvement work
- Development of a Maternity and Neonatal Safety Board for on-going oversight of Quality and Safety in services ward to board beyond special measure status
- Legacy plans
 - Legacy learning boards
 - Quarterly local learning events
 - Annual national learning event (Royal College of Midwifery (RCM) keen to support)
 - Annual student presentations (already in development in conjunction with RCM/WG mentoring and learning programme)
- Service development with neonatal colleagues to be re-started – initially in respect of Transitional Care arrangements
- Pre-conception care to be reviewed with Systems Director
- Gynaecology ‘hubs’ work to be refreshed and re-started