AGENDA ITEM
4.2

CTM BOARD

MATERNITY AND NEONATAL SERVICES: AN UPDATE

Date of meeting	27/05/2021
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 and 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**
Quality & Safety Committee	18/05/2021	NOTED
Management Board	19/05/2021	NOTED

ACRONYMS	
NNU	Neonatal Unit
PCH	Prince Charles Hospital

RGH	Royal Glamorgan Hospital
POW	Princess of Wales Hospital
RCOG	Royal College of Gynecologists
IMSOP	Independent Maternity Oversight Panel
SIs	Serious Incidents

1. SITUATION/BACKGROUND

1.1 This paper provides a position update with regard to the IMSOP review and associated improvements relating to Health Board Maternity services and Neonatal services.

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

2.1 Neonatal Deep Dive

2.1.1 Internal communications and support
The IMSOP Neonatal Team will commence a deep dive review on 10 May 2021 with the same progressing over a 20 week period at PCH. Communications to key staff have been issued with offers of support and opportunities provided at regular intervals to keep staff updated. As part of facilitating that support, workforce and staff side colleagues have also been kept informed. It should be noted that this will involve staff working on all of the acute sites.

2.1.2 External communications with partners
The detail of the same is currently being agreed with IMSOP

2.1.3 Family engagement
IMSOP are planning to offer all families who accessed Neonatal services at PCH June 2020-December 2021 an opportunity to be part of the service review. The governance and the detail of this is being worked through with IMSOP

2.2 Progress in submission against the RCOG recommendations
Work is progressing to submit evidence against the remaining 7 of the 16 recommendations being monitored by IMSOP; by the end of June

2.3 Clinical Reviews
A small number of the Stillbirth IMSOP clinical reviews involve Neonatal services and as such Neonatal services have aligned to the Maternity service processes to manage and respond to the same

Information is pending from IMSOP with regard to the third phase of the IMSOP clinical reviews and when the Neonatal Morbidity and Mortality category will begin to be shared with the Health Board

2.4 Developments and progress

A prototype neonatal dashboard has been drafted using the All Wales Neonatal standards and is under review by the Maternity & Neonatal Improvement Board (MNIB) and the Integrated Locality Groups (ILGS).

2.3 Maternity Services

2.3.1

The service has completed 53 out of 70 recommendations.

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

The New Programme Director has commenced in post and further work will be undertaken to review the content of work stream plans in respect of delivering on the remaining recommendations, and also the role of the work stream lead and wider programme management and governance

2.3.2

We have now received all 63 of the cases in the stillbirth category. Action plans have been developed to address the review findings of each case by a multi-disciplinary team (MDT). Evidence of any completed actions is compiled and considered by the MDT Clinical Cabinet to ensure a robust response. IMSOP began writing to women in the Stillbirth Category in April to inform them the review of their care is complete. This will continue throughout May and June, and we continue to prepare Health Board responses detailing our improvement for each family requesting feedback, and to date two Health Board letters have been received by families, with a further 6 letters to be sent week commencing the 10 April 2021.

2.3.4

The Maternity and Neonatal Improvement Programme Director commenced in April 2021 and has begun an in-depth review of the programme and remaining recommendations.

The new MIT project officer will commence in role on the 17 May 2021.

The job description for the Quality Improvement Post has been approved and will be advertised shortly.

We await approval for the Engagement and Experience Lead post.

2.3.5

Maternity Services Serious Incident Backlog

The service has now completed 12 from the backlog of 43 (previously 44, 1 case now downgraded).

Maternity current SI Progress	28th April	10th May
Awaiting start	0	0
In progress Maternity	15 (9 requiring Neonatal review)	14 (13 requiring Neonatal review)
Senior Mat service QA	16 (11 require neonatal input prior to QA)	17 (13 require neonatal input prior to QA)
Senior Neo service QA	2 (of the 16 above)	2 (of the 17 above)
Exec Approval		
HB sign off	12	12
WG sign off		
	43	43

The new Senior Midwife (former Head of Midwifery) to support quality assurance to ensure on-going 'fresh-eyes' will commence shortly.

Welsh Government and the IMSOP panel have recently reviewed a number of the submitted investigations. There are clear improvements noted, however a number require further improvement relating to consultant engagement, and joint working. We are awaiting formal written feedback.

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.
The service has 12 actions outstanding with clear actions plans in place.

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

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

- The development of key neonatal performance indicators has been progressed and a prototype is under review by colleagues within the ILGs and through review at MNIB

- Whilst Quality Improvement (QI) training was unavailable the team continued to progress the development of a new health board wide Neonatal documentation and record keeping system and protocol; aiming for June 2021 launch
- QI methodology is proposed to support the innovations through an improvement framework; with a small QI team trained on each site and with training dates now being provided
- Engagement strategy development is underway with great examples of virtual activity including virtual ward rounds and virtual clinics with excellent feedback
- The Maternity PREM did not go live in April as planned due to issues with Health Board implementation, we await an update from the Health Board Lead
- Leadership development for new teams in the Women's and Children's Directorate is currently being scoped in house and the next meeting is taking place on the 14 May 2021
- The Health Board Strategic Lead for Wellbeing has now commenced meetings with staff from Maternity Services as part of the bespoke wellbeing project

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
The Board is asked to **NOTE** the content of the paper.