Meeting Date	**22 August 2019**	**Agenda Item**	**3.3**
Report Title	**Update on the action plan for Swansea Bay University Health Board maternity service in response to the publication of the RCOG and RCM report "Review into maternity services in Cwm Taf" (2019)**		
Report Author	Sue Jose, Acting Head of Midwifery		
Report Sponsor	Cathy Dowling, Assistant Director of Nursing & Patient Experience		
Presented by	Gareth Howells, Director of Nursing & Patient Experience		
Freedom of Information	Open		
Purpose of the Report	To provide an overview of the Swansea Bay University Health Board response to the publication of the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives published report, following a review into maternity services in Cwm Taf Health Board from the 15th to the 17th January 2019. An accompanying report "Listening to women and families about Maternity Care in Cwm Taf" describes Women's experience		
Key Issues	The Swansea Bay maternity multi-disciplinary leadership team, supported by the Associate Nurse Director and Service Delivery Unit leadership teams, completed a self-assessment of the maternity services, using a RAG rating in relation to each of the 70 recommendations contained within the RCOG/RCM report. The report was submitted to Welsh Government 15th May 2019. No RED ratings were identified, 24 AMBER and 38 GREEN. 8 recommendations were not applicable to Swansea Bay UHB. Up to the end of July 2019 14 AMBER ratings have become GREEN. 10 AMBER ratings remain for further actions. Maternity services have been transferred to Singleton Hospital Delivery Unit for management systems with a view to create a Women's service group in the future to incorporate gynaecology and early pregnancy care Continued and ongoing improvement of the maternity dashboard		

<table>
<tr><td></td><td colspan="4">The maternity service will need to review the available resource for the management of the serious incidents and governance requirements for maternity services (incidents, complaints, risks)

Swansea Bay UHB will need to decrease the rate of stillbirth. 2 significant themes identified in serious incident reporting which impact on the stillbirth rate include;
• Adherence to the GAP/GROW programme for foetal growth surveillance by ultrasound scan in pregnancy. Ultrasound capacity is under intense pressure across the service
• Improved interpretation and actions taken in the presence of abnormal cardiotocograph monitoring of foetal well-being. Actions currently in progress include preparation of business cases to be submitted to the Investment and Benefit Group for a foetal surveillance midwife and ultimately a cardiotocograph central monitoring system to support clinicians in practice, for training purposes and maintenance and storage of cardiotocograph traces for litigation purposes.

All maternity service training to meet Welsh Government standards should be measureable on ESR however the system is currently not set up for this.</td></tr>
<tr><td rowspan="2">Specific Action Required
(please choose one only)</td><td>Information</td><td>Discussion</td><td>Assurance</td><td>Approval</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Recommendations</td><td colspan="4">Members are asked to:
• NOTE</td></tr>
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Update on the action plan for Swansea Bay University Health Board maternity service in response to the publication of the RCOG and RCM report "Review into maternity services in Cwm Taf" (2019)

1. INTRODUCTION

This report will provide an overview of the Swansea Bay University Health Board response to the publication of the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives published report following a review into maternity services in Cwm Taf Health Board from the 15th to the 17th January 2019.

2. BACKGROUND

The Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM), published a report of the review into maternity services in Cwm Taf Health Board in May 2019. The report identified significant failings within the service including;

- Under reporting of Serious incidents with basic governance processes not in place
- Sub-optimal clinical and managerial leadership
- Shortfall in midwifery establishments
- Significant use of locums
- Lack of established standards of practice

In response to the publication of the report Dr Andrew Goodall, the Chief Executive of the NHS in Wales wrote to the Chief Executive of the Health Board to seek assurance of the safety of maternity services in Swansea Bay University Health Board.

The Swansea Bay maternity multi-disciplinary leadership team, supported by the Associate Nurse Director and Service Delivery Unit leadership teams, completed a self-assessment of the maternity services, using a RAG rating in relation to each of the 70 recommendations contained within the RCOG/RCM report. The report was submitted to Welsh Government 15th May 2019. No RED ratings were identified, 24 AMBER and 38 GREEN. 8 recommendations were not applicable to Swansea Bay UHB.

An oversight group led by the Director of Nursing will monitor progress where Swansea Bay UHB self-assessed an AMBER rating against the recommendations, and the actions taken toward GREEN rating. The action plan will be updated and achievement toward completion of the actions will be reported through the Quality & Safety Forum.

3. GOVERNANCE AND RISK ISSUES

Up to the end of July 2019 14 AMBER ratings have become GREEN. 10 AMBER ratings remain for further actions. The issues set out are related to the outstanding AMBER issues.

The maternity service structure was devolved to three service delivery units in response to the Andrews report (2015). While the Head of Midwifery team continued

to have Health Board wide professional leadership, there were challenges to ensure the Executive Board retained oversight of the service as a whole. Maternity services from 1st July 2019 will be managed within the Singleton Hospital Service delivery Unit. Initial management will be within the surgical services unit while a wider health Board restructure takes place. The aim is to develop a Womens service group that will incorporate gynaecology and early pregnancy assessment unit- an area raised as a particular concern in Cwm Taf Health Board. There is currently no time frame to conclude the development of the service group.

The maternity dashboard is being updated to ensure clinicians at all grades have access to performance data for the maternity service. Currently this information is maintained on the electronic dashboard with limited access for clinicians.

An all Wales trigger list for serious incidents is in preparation with Welsh Government and Welsh Risk Pool. Swansea Bay have a positive reporting culture of incidents and robust review. Improvement will be made with the introduction of the new serious incident toolkit. Maternity services are working with the Health Board Serious Incident team to embed in practice.

The maternity resource for managing the governance agenda will need to be reviewed. There is a Band 7 governance manager and band 6 governance facilitator who provide governance support for maternity and paediatrics. The team are funded through maternity. A Clinical lead for Obstetrics has been appointed and is provided 2 sessions within their job plan. There is no midwifery governance lead at a senior level (8a). The Intrapartum lead midwife who works 22.5 hrs is currently fulfilling the post- leaving a labour ward management gap. The maternity service are working with neonatal and anaesthetic colleagues to ensure the governance processes for maternity is streamlined. Two new meetings have been agreed for the multi-disciplinary team to ensure improved process for enhanced management of issues.

Swansea Bay UHB will need to decrease the rate of stillbirth. 2 significant themes identified in serious incident reporting which impact on the stillbirth rate include;
•Ultrasound scan capacity as it related to the GAP/GROW programme is an issue. The maternity service has never fully adhered with the GAP GROW programme including exceptions where there was not the scan capacity available. It was agreed at the last quarter antenatal forum to include all risk factors for GAP/GROW and offer serial scans. This will put increased pressure on ultrasound capacity. A meeting is being arranged with the radiology management to plan going forward.
•Failure to interpret and act on abnormal cardiotocograph traces. The issue of cardiotocograph monitoring was highlighted in the Cwm Taf report. A business case has been submitted to Investment and benefit group for a central monitoring system for foetal surveillance that will support clinical practice and education & training for all maternity health professionals. The central monitoring system is an expensive and complex system change involving maternity health professionals, Information Technology teams finance and procurement therefore a first step toward enhanced foetal monitoring is a bid to the Investment and benefit group for a foetal surveillance midwife for two years. The midwife would work over 5 days and be available in the clinical area to improve knowledge levels, review cases to aid learning and work with staff on a day to day basis in preparation for an electronic solution. The midwife will also be responsible for training and holding reflective workshops. The Chief

Executive was supportive of the Foetal Surveillance midwife project at a recent Sennedd meeting.

All maternity service training to meet Welsh Government standards should be measureable on ESR however the system is currently not set up for this.

4. FINANCIAL IMPLICATIONS

Maternity service is a high litigation service.

5. RECOMMENDATION

To continue to progress work toward a Womens service group structure to incorporate gynaecology and early pregnancy assessment unit
To further refine and improve the maternity dashboard
To embed the serious incident toolkit and ensure all investigations are multi-disciplinary have family involvement and support, are robust and completed in a timely manner
To review the governance structure to include a senior clinical lead for midwifery to work with the obstetric clinical lead, the governance team and relevant midwifery staff
To complete the investment and benefit group proposal for a foetal surveillance midwife while the large scale proposal for central cardiotocograph monitoring system is completed.
For all Welsh standards for training of maternity staff to be captured on ESR
For the Director of Nursing group to maintain oversight and scrutiny of the action plan delivery.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☐
	Timely Care	☐
	Individual Care	☐
	Staff and Resources	☒

Quality, Safety and Patient Experience

The recommendations of the RCOG/RCM report into maternity service provision at Cwm Taf health Board identified significant failings within the service

Swansea Bay UHB maternity services has self-assessed against the report recommendations with 24 AMBER ratings for action required, reduced to 10 AMBER actions in July 2019

To ensure the Executive Board and Welsh Government are assured of the safety of maternity services in Swansea Bay UHB

To ensure families are involved in all investigations into care where a serious incident has been reported to Welsh Government. This will ensure The health board are responding to all issues raised by the family

The Director of Nursing will chair a group who will retain scrutiny and oversight of the action plan delivery

Financial Implications

Maternity services are a high litigation service

Legal Implications (including equality and diversity assessment)

Maternity services are a high litigation service.

Staffing Implications

See financial implications.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)	
A healthy start in life for all babies born in Wales.	
Report History	First report.
Appendices	