Meeting Date	**23rd February 2023**	**Agenda Item**	**3.2**
Report Title	**Maternity Services Assurance Paper**		
Report Author	Catherine Harris, Deputy Head of Midwifery		
Report Sponsor	Lesley Jenkins, Group Nurse Director/ Associate Nurse Director		
Presented by	Catherine Harris, Deputy Head of Midwifery		
Freedom of Information	Open		
Purpose of the Report	This paper will provide the Quality & Safety Committee with an update on maternity services self-assessment against recent National reviews.		
Key Issues	• Update on assurance of the safety of the Health Board maternity service. • Publication of two reports from NHS England in 2022 regarding failing maternity services. • Update on the Wales Maternity and Neonatal Safety Programme (Mat-Neo SSP). • Update on the Health Board self-assessment tool as prepared by the Wales Maternity and Neonatal network. • Draft baseline assessment tool developed for East Kent Report (Kirkup 2022).		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐

Recommendations	Quality & Safety Committee are asked to: 1. Note the initial assessment against the assurance framework for maternity services, submitted in draft to WG on 8th June 2022. 2. Note baseline assessment tool for East Kent Report. 3. Note the reported progress of the Mat-Neo SSP 4. Agree to receive quarterly updates against the action plan and assurance framework, presented by the Head of Midwifery on behalf of the multi-disciplinary team.

Maternity Services Assurance Paper

1. INTRODUCTION

This paper will provide Quality & Safety Committee with an update of the maternity service assurance following the publication of two national reports of external reviews of NHS Trusts in England.

2. BACKGROUND

In 2019 the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives (RCOG/RCM), published their external review of maternity services in the then Cwm Taf Health Board (2019) in Wales (Appendix 1). Following publication of the report each Health Board in Wales were required to provide assurance to the Welsh Government of the quality and safety of their maternity service. National work streams in response to the publication of the Cwm Taf Health Board report (2019) included Healthcare Inspectorate Wales national review of the quality and safety of maternity services (2020) (Appendix 2), and the Welsh Government commissioned and planned the Maternity and Neonatal Safety Programme (Mat-Neo SSP) led by Improvement Cymru.

In 2022, two reports of external reviews in NHS Trusts in England were published in March and October*. "Findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust (Ockenden 2022)* (Appendix 3), followed by *"Reading the signals. Maternity and neonatal services in East Kent – the Report of the Independent Investigation (Kirkup 2022)* (Appendix 4). Following publication of the Ockenden report (2022), the Chief Midwifery Officer (CMO) informed the Heads of Midwifery Wales that Welsh Government was seeking a proportionate response due to the ongoing discovery phase of the planned Mat-Neo SSP.

The Maternity and Neonatal Network developed an assurance framework for Health Board self-assessment, approved by the Chief Nursing Officer and circulated to Health Boards, which was received by the maternity service on 17th May 2022 (Appendix 5). The CMO confirmed the expectation for Health Boards to submit the embedded templates for RED and AMBER self-assessment by 27th May 2022. The self-assessment was completed and submitted to the Health Board Chief Executive and Executive Nurse Director on 24th May 2022 (Appendix 6).

A national meeting hosted jointly by Welsh Government and the Wales Maternity and Neonatal Network for maternity service clinical leaders took place of 7thJuly 2022 to review the seven Health Boards self-assessment documents in order to consider national priorities for investment. A second national meeting of clinical leaders

followed on 6th September 2022 led by the Independent Maternity Services Oversight Panel (IMSOP), set up by Welsh Government in response to the RCOG/RCOM Cwm Taf Health Board review for extended learning opportunities.

The Kirkup (2022) report into East Kent maternity services was published in October 2022. The report author concluded in light of the number of reviews of maternity services, conventional reports, with multiple and overlapping recommendations have not stopped the failings, the missed opportunities or in lessons leading to improvements at any level. For this reason, the Investigation identified four key areas the NHS could be better at;

- At identifying poorly performing units.
    - Monitoring safe performance - finding signals among noise
- At giving care with compassion and kindness.
    - Standards of clinical behaviour - technical care is not enough
- At team working with a common purpose.
    - Flawed team working - pulling in different directions
- At responding to challenge with honesty
    - Organisational behaviour - looking good while doing badly

The recommendations identified in the report, are predominantly directed at national professional bodies and service providers including education institutes and will be incorporated into the Mat-Neo SSP work stream.

3. GOVERNANCE AND RISK ISSUES

Swansea Bay University Health Board Maternity services are fully engaged with the Mat-Neo SSP who provided a programme update in December 2022 (Appendix 7). Two local champions have been appointed into post and a Mat-Neo SSP Clinical Site Visit is due to take place Thursday 19th January (Appendix 8 & 9). The review team will include representatives from the Wales Maternity & Neonatal Network, the Mat-Neo SSP National Team and Improvement Cymru. Two reviewers will be in attendance to meet with the executive team.

Further developments related to the Mat-Neo safety programme include the Birthrate+ Cymru Project and Digital Maternity Cymru. The Birthrate+ Cymru assessment has been received into the Health Board and will be incorporated into the wider workforce review for future service delivery. The Service Group is also investing in a fixed term appointment for Workforce Transformation Midwife to support workforce development opportunities for the unregistered workforce and top of licence working for registered midwives. The Welsh Government have approved initial funding for a Digital Midwife

to support the work of the Digital Maternity Cymru Project Board to introduce a national maternity information system to Wales.

As previously reported to Quality & Safety Committee, a number of the issues included in the combined assurance framework developed by the Wales Maternity & Neonatal Network can only be achieved by a National response. The agreed output from the national meeting of maternity and neonatal service leaders held on 7th July and 6th September was to develop national and local actions for service. No feedback from the events has been received to date.

The initial self-assessment of the service utilising the Wales Maternity and Neonatal network assurance document is unchanged and the 78 recommendations RAG rated as below in Table 1:

- GREEN - 56
- AMBER - 16
- RED - 5 (2 of which require a national response)

Table 1. Outstanding RED actions:

Recommendation	**Issues preventing assurance & Risk description**	**Initial Risk Score**	**Mitigating Action for short term**	**Revised Risk Score**
3.2. Midwives responsible for co-ordinating labour ward must attend a funded and nationally recognised labour ward coordinator education module. This must be a specialist post with an accompanying job description	-generic job description in use. -no specific labour ward training module available; Risk – patient safety risk if coordinator does not have the skills to maintain an overview of unit activity and safety.	15	-Maternity management team to continue to provide peer and line manager support for newly appointed labour ward coordinators. -Specific job description to be developed.	10
3.3. Health Boards must ensure newly appointed labour ward co-ordinators receive an orientation package which reflects their individual needs.	-generic induction programme is provided. Risk – patient safety risk if coordinator does not have the skills to maintain an	15	-Newly appointed coordinators supported by their peers and the management team -Bespoke induction	10

	overview of unit activity and safety.		programme to be developed	
4.1. Take steps to ensure that women have contact with a consistent group of healthcare professionals, to improve continuity of care.	-current staffing levels in community services do not favour continuity of carer. Risk – communication between professionals may lead to important issues being overlooked, risk of harm to mother and/or baby. Lack of time to develop meaningful communication between mother and midwife.	15	-recruitment to vacant posts underway -new workforce model to be developed	6

The Maternity service multi-disciplinary team plan to convene to undertake an updated self- assessment of the framework by the end of February 2023.

Following publication of East Kent report Welsh Government have advised that all Health Boards undertake a self-assessment to provide assurance against the report however they have not asked for a submission at a national level. The broad themes of the report recommendations have been identified in previous maternity service reports and will be incorporated into the Mat-Neo SSP. Whilst there is no national self-assessment tool a baseline assessment tool using the key recommendations and key actions (Appendix 11) has been developed by the service group for additional assurance. The benchmark exercise has not been completed due to service pressures and is planned for completion by the end of February 2023.

To support early dissemination of learning a *"7-minute briefing"* of the main findings of the report has been prepared and circulated to all maternity and neonatal staff groups (Appendix 10).

5. FINANCIAL IMPLICATIONS

The financial implications of this work cannot be estimated at this time. The Mat-Neo SSP will report incorporating the findings of national reports into maternity services, with recommendations for improvement.

6. RECOMMENDATION

It is recommended that the Quality & Safety Committee note the report and support the actions being taken by the Maternity Services to ensure compliance with the recommendations from local and national reports.

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 quality and safety of the Health Board maternity service is a key enabler for future generations giving the best start in life to families.		
Financial Implications		
The financial implications of the Mat-Neo SSP are unknown at this time.		
Legal Implications (including equality and diversity assessment)		
Not required		
Staffing Implications		
The two year fixed term advert for a Workforce Transformation Midwife is on TRAC. Digital maternity Cymru are providing initial funding for a Digital Midwife. The wider staffing implications are unknown at this time		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
An Excellent maternity service provides women, babies and families the best start in life.		
Report History		
Appendices		