Meeting Date	20 August 2019	Agenda Item	4.3
Report Title	**Update on the actions relating to Workforce O&D from the Swansea Bay University Health Board, Maternity Service action plan following publication of the RCOG and RCM report *"Review into maternity services in Cwm Taf"* (2019)**		
Report Author	Susan Jose, Acting Head of Midwifery		
Report Sponsor	Gareth Howells, Director of Nursing & Patient Experience		
Presented by	Gareth Howells, Director of Nursing & Patient Experience		
Freedom of Information	Open		
Purpose of the Report	To provide and update to Workforce O&D Committee on progress against the above action plan		
Key Issues	The Swansea Bay Maternity Multi-Disciplinary Leadership Team, supported by the Associate Nurse Director and Service Delivery Unit Leadership Teams, completed and submitted to Welsh Government on the 15th May 2019 a self-assessment of the Maternity Service. A RAG rating was used in relation to each of the 70 recommendations contained within the RCOG/RCM Report. RAG Rating: RED – None identified AMBER – 24 identified (updated to 8 @9/8/19) GREEN – 38 identified (updated to 54 @9/8/19) 8 recommendations were not applicable to Swansea Bay UHB. The key issues identified which are relevant to the Board Workforce & OD Committee are: a) Governance resource b) CTG training c) PADR compliance d) Staffing in line with national guidance e) Induction for locum staff **a) Governance resource** 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)		

<table>
<tr><td></td><td colspan="4">b) CTG training
All CTG training is recorded in a ‘CTG Passport’. The current training programme includes:
• training for midwifery and obstetric staff as part of the Mandatory & Statutory Training Day
• additional self-directed study
The training is provided by clinicians who have volunteered for the role and the time is taken from their clinical commitments

A business case is being prepared for the Investment and Benefit Group for a ‘Fixed Term’ Foetal Surveillance Midwife. A key requirement of this role will be for the individual to develop their skills to a specialist level to further develop the knowledge and skills in CTG interpretation in both a formal classroom and within the clinical setting.

c) PADR compliance
There is a discrepancy between the data obtained from ESR and local data which reports higher compliance. Work is currently being undertaken by the Midwifery Matrons to establish why this discrepancy exists, to review local processes and work with ESR to rectify.

d) Staffing in line with national guidelines
Staffing levels are currently within RCOG and Birth Rate+ recommendations

e) Induction programme for locum staff
An induction programme is not currently available for locum staff and is in development.</td></tr>
<tr><td>Specific Action Required
(please choose one only)</td><td>Information
☐</td><td>Discussion
☒</td><td>Assurance
☐</td><td>Approval
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<tr><td>Recommendations</td><td colspan="4">Members are asked to:
• CONSIDER</td></tr>
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Update on the actions relating to Workforce O&D from the Swansea Bay University Health Board, Maternity Service action plan following publication of the RCOG and RCM report *"Review into maternity services in Cwm Taf"* (2019)

1. INTRODUCTION

This report will provide an overview to the Workforce O&D Committee of the Swansea Bay University Health Board response to the publication of the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM) published report following a review into Cwm Taf Health Board Maternity Services from the 15th to the 17th January 2019.

2. BACKGROUND

The RCOG and RCM published a report of the review into Cwm Taf Health Board Maternity Services 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 Swansea Bay UHB to seek assurance of the safety of Swansea Bay UHB Maternity Services.

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 Service, 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 on the 15th May 2019.

No RED ratings were identified, 24 were rated as AMBER and 38 rated as GREEN. 8 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 and the Workforce O&D Committee.

3. GOVERNANCE AND RISK ISSUES

As of August the ratings were updated to:
AMBER – 8

GREEN – 54

The issues set out are related to the outstanding AMBER issues.

a) Governance resource

An All Wales Maternity Trigger List for Serious Incidents is in development with Welsh Government and Welsh Risk Pool input. Swansea Bay UHB Maternity Service has a positive reporting culture of incidents and a robust review process. It is expected there will be an increase in serious incident reporting following the introduction of the trigger list.

SBU HB Maternity services are working with the SBU HB Serious Incident Team to embed the new Serious Incident Toolkit process into practice. The new process is robust and provides a clear framework for the management of serious incidents, however it is recognised there is an increase in resources required in order to deliver the incident/case review, and meet with the family where required, within the stipulated timeframe. The Maternity and Children's Services resource consists of a Band 7 Governance Manager and Band 6 Governance Facilitator/Data Lead who provide support to both services for the full governance agenda. Consideration to increase this resource will need to be explored. The team are funded through Maternity Services.

A Clinical Lead for Obstetrics has been appointed and is allocated 2 sessions within their job plan. There is no Midwifery Governance Lead at a senior level (8a). The Intrapartum Lead Midwife, who works 22.5hrs, is currently fulfilling the post which leaves a gap in the management of Labour Ward which cannot be sustained.

SBU HB Maternity Service is working with neonatal and anaesthetic colleagues to ensure the governance process is streamlined. Meetings have been agreed to ensure an improved multi-disciplinary team process for enhanced management and reporting of issues. This multi-team review process is also a recommendation from Each Baby Counts, the RCOG national quality improvement programme and MBRRACE-UK (Mothers and Babies : Reducing Risk through Audits and Confidential Enquiries across the UK) Perinatal Mortality Surveillance Report. Again this requires additional resources to ensure maternity involvement.

b) Foetal Surveillance

Swansea Bay UHB needs to decrease the rate of stillbirth and incidence of Hypoxic Ischaemic Encephalopathy (HIE) Grade 2 and 3.

Two significant themes identified in serious incident reporting which impact on the stillbirth and HIE rate include:

- Ultrasound scan capacity to comply with the GAP/GROW programme.
  A meeting is being arranged with the Radiology Management Team to plan how to take this forward.

- Failure to interpret and/or act on abnormal cardiotocograph (CTG) traces.
  Significant concerns were raised in the RCOG/RCM report in relation to the:
  - quality and quantity of CTG training provided

- failure of the Health Board to provide robust evidence of compliance with the mandatory training requirements.

SBU Maternity Service currently provides training to appropriate staff in line with the Welsh Government Standards and includes:

- 4hrs training for midwifery and obstetric staff as part of the Mandatory & Statutory Training Day
- 2hrs additional self-directed study

The training is provided by clinicians who have volunteered for the role and take time out from clinical duties to deliver the programme.

A business case for a Central Monitoring System for Foetal Surveillance is currently being progressed for submission to the Investment and Benefit Group. The system supports clinical practice for all maternity health professionals and provides clinicians with the ability to view the trace on a central screen. This enables a full multi-disciplinary discussion to take place without worrying the mother or disturbing the care she is receiving.

The Central Monitoring System is expensive and involves a complex system change which requires a multi-faceted approach from maternity health professionals, Information Technology teams, Finance and Procurement. Therefore a first step toward enhanced foetal monitoring is to employ a Specialist Foetal Surveillance Midwife. A business case is being written for a Foetal Surveillance Midwife (Band 7) for a 2 year fixed term period. The Midwife, who would be a specialist in CTG interpretation, would work over 5 days 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, holding reflective workshops and working with midwives and doctors who have been involved in a case where an abnormal CTG was a factor.

The Chief Executive was supportive of the Foetal Surveillance Midwife project at the May 2019 Welsh Government scrutiny panel at the Senedd.

c) PADR and training compliance

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

In relation to PADR data, there is a discrepancy between the data obtained from ESR and local data which reports higher compliance. Work is currently being undertaken by the Midwifery Matrons to establish why this discrepancy exists, to review local processes and work with ESR to rectify.

d) Staffing in line with national guidance

Midwifery staffing levels are currently compliant with Birth Rate+ recommendations. Medical staffing is RCOG compliant.

e) Induction for locum staff

There is currently no induction programme for locum medical staff. Whilst it is acknowledged that it is a rare occurrence to employ a locum unknown to the service, the lack of an induction programme has been highlighted.

SBU HB Maternity Service is reviewing the information provided to locum staff with a view to using social and electronic media to provide unit information to the individual before they attend the unit.

4. FINANCIAL IMPLICATIONS

Maternity Service is a high litigation service. SBU HB Patient Experience, Risk and Legal Services Team have provided the Head of Midwifery with a breakdown of claims settled during a recent 5 year period. The recurring theme for the majority of cases, particularly those which paid damages in excess of £500,000 relates to the misinterpretation of the CTG.

5. RECOMMENDATION

1) To review the available resource for managing the Maternity and Children's Services governance processes following the full implementation of the Health Board Serious Incident Toolkit and pending the introduction of the All Wales Serious Incident Trigger List. It is proposed this structure will include a senior clinical lead for midwifery to work with the obstetric clinical lead, the governance team and relevant midwifery staff.
2) Seek the support of the Investment and Benefit Group for the proposed 2 year fixed term Foetal Surveillance Midwife role in order to improve knowledge and skills in the interpretation of CTG while awaiting the full business case for central monitoring to be processed and approved.
3) For all Welsh Standards for training of maternity staff to be captured on ESR.
4) For the Workforce O&D Committee 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

- When things go wrong women and families must expect a full, thorough and timely review is undertaken
- Women expect a positive outcome to birth when there are no anticipated complications. SBU HB is currently an outlier for stillbirth rates.
- Improved training and development of staff knowledge in relation to CTG interpretation will improve and reduce stillbirth and HIE rates.

Financial Implications

The finance for any new roles in the midwifery establishment is not available within budget. The boundary change with Cwm Taf has led to a reduction in the Heads of Service budget equating to £44k which must be absorbed this financial year as both the Head of Midwifery and Deputy Head of Midwifery remain in post with no reduction in workload.

The Investment and Benefit Group will be asked to consider the Foetal Surveillance Midwife role as the most significant need for the service. This will be the cost of a 1.0WTE Band 7 Midwife for a fixed term of 2 years (£53k per annum).

Legal Implications (including equality and diversity assessment)

N/A

Staffing Implications

N/A

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)
Briefly identify how the paper will have an impact of the "The Well-being of Future Generations (Wales) Act 2015, 5 ways of working. ○ **Long Term** - Support and involvement of families in the serious incident review process will help them come to terms with what went wrong and seek timely support preventing long term implications. ○ **Prevention** – Babies have the best start in life if they are born well grown and healthy. Improved knowledge and skills for CTG interpretation and action will support this goal. ○ **Integration –** SBU HB is working to decrease the stillbirth rate and incidents of brain injury (HIE). This will benefit women, their families and the general population by providing a healthy start in life for babies. ○ **Collaboration –** Working with women and their families by involving them in investigations and providing feedback on the findings. ○ **Involvement –** Obstetric and Midwifery staff will benefit from the support of a dedicated specialist midwife to further develop their knowledge and skills in CTG interpretation.

Report History	A separate report on the RCOG/RCM report response was submitted to Quality and safety forum 25th June 2019 2019-07-15-submissi on for Quality and Saf
Appendices	review-of-maternity-s ervices-at-cwm-taf-he Action Plan.docx