Meeting Date	**26 July 2022**	**Agenda Item**	**3.1**
Report Title	**Quality & Safety Committee Update of the Welsh Government Planned timetable for assurance of the safety of the health board maternity service.**		
Report Author	Susan Jose, Head of Midwifery		
Report Sponsor	Gareth Howells, Executive Director of Nursing & Patient Experience		
Presented by	Susan Jose, Head of Midwifery		
Freedom of Information	Open		
Purpose of the Report	To inform the Quality & Safety Committee of the updated plan for maternity service assurance requested by Welsh Government following the publication of the Ockenden Report.		
Key Issues	• Assurance of the safety of the Health Board maternity service. • Welsh Government request for Health Board self assessment utilising an assurance framework prepared by the maternity and neonatal network. • Welsh Government timetable set for national and local assurance. • The self assessment will support recognition of national priorities to feed into the maternity and neonatal safety programme. • Improvement plan to be developed and monitored during the timetable of events and reported to Quality & Safety Committee at agreed dates.		

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

Recommendations	Quality & Safety Committee is asked to : - Note the initial assessment against the assurance framework for maternity services, submitted in draft to WG on 8th June 2022.

	- Agree the baseline risk assessments for the red RAG rated areas, and the short-term actions associated with them. - Agree to receive an update following the national meeting on 7th July. - Note that the action plan will be further developed following the meeting on 7th July. - 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.

Quality & Safety Committee Update on the Welsh Government timetable for assurance of the safety of the Health Board maternity service.

1. INTRODUCTION

This report provides an update to the Quality & Safety Committee for the updated Welsh Government Planned timetable for assurance of the safety of the health board maternity service following the publication of the Ockenden Report.

2. BACKGROUND

On 30th March 2022 the Ockenden Final Report Independent Review of SatH Shrewsbury and Telford Hospital Trust (SaTH) was published.

On publication of the report the Chief Midwifery Officer (CMO) shared with the Heads of Midwifery Wales that the Welsh Government was seeking a proportionate response to the report. The request was to consider the ongoing work of the planned maternity and neonatal safety programme instigated in response to previous significant reports, including the RCOG/RCM report into maternity services in Cwm Taf Health Board (as it was called at the time of publication of the report (RCOG/RCM 2019), and Healthcare Inspectorate Wales (2020) National Review: Maternity Services, Phase One, National Review of the Quality and Safety of Maternity Services.

The Maternity and Neonatal Network developed an assurance framework incorporating the three key report recommendations (Appendix 1). This assurance document was approved by the Chief Nursing Officer office and circulated to Health Boards in a letter dated 13th May 2022, received by the maternity service on 17th May 2022 (Appendix 2).

A meeting was held with the CMO on 17th May 2022 to clarify guidance for completion of the assurance document due to the request for a response by 27th May 2022.

The CMO confirmed that Health Boards were required to undertake a self assessment against the assurance document and submit exception reports using the embedded template for RED & AMBER self assessed issues only.

The maternity leadership team met on 23rd May 2022 to complete the RAG ratings for each issue. The team included the Obstetric Clinical lead, Obstetric Governance lead, Consultant Anaesthetist, Head of Midwifery, Deputy Head of Midwifery and Governance Manager. The exception report documentation was completed on 24th May 2022 for submission to the Chief Executive, Executive Nurse Director and the Neath Port Talbot Singleton Service Group senior management team prior to submission by the deadline.

The completed assurance document when submitted to Welsh Government will be reviewed along with the seven Health Board submitted documents to benchmark and consider national priorities for investment for improvement.

The assurance document will be the focus of a national meeting planned for 7th July 2022 for the seven Health Boards' maternity service clinical leaders.

A second national meeting will take place 6th September 2022 led by the IMSOP (Independent Maternity Services Oversight Panel) team for the extended learning from Cwm Taf Health Board.

3. GOVERNANCE AND RISK ISSUES

A number of the issues included in the assurance framework can only be achieved by a national response. This issue was raised at the meeting on 17th May 2022 with the CNO.

The completed assurance document with completed exception templates (Appendix 3), is attached as prepared by the maternity team senior leadership. There is no standardised methodology for completing the self assessment using the assurance framework provided. The rapid turnaround of the document has not allowed time for detailed narrative to be developed, or for detailed risk assessments. Ongoing collection of supporting evidence and approved risk assessments will continue beyond the submission date.

An action plan for immediate assurance for local red ratings will be developed by 25th June 2022. Following the planned national meeting on 7th July 2022 and completion of benchmarking across the seven health boards, the action plan will be updated to confirm agreed national and local actions for development and monitoring purposes.

The assurance document contains 78 recommendations. The initial RAG ratings for Swansea Bay Health Board are 56 GREEN, 16 AMBER and 6 RED.

Of the RED ratings 3 require a national response.

The table below provides a summary of the risks associated with those 3 recommendations that have been rated as RED, with initial risk scores and the mitigating actions, where these are local issues. Where these risks are not already reflected on the risk register, they will be added by 17th June 2022. It should be noted that some of the actions require collaborative work with other Health Boards and HEIW as outlined in the exception templates at Appendix 3, which also includes the timescales and person accountable for the 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 overview of unit activity and safety.	15	-Newly appointed coordinators supported by their peers and the management team -Bespoke induction programme to be developed	10
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	15	-recruitment to vacant posts underway -new workforce model to be developed	6

	being overlooked, risk of harm to mother and/or baby. Lack of time to develop meaningful communication between mother and midwife.			

4. FINANCIAL IMPLICATIONS

The financial impliacations of this work cannot be estimated at this time. In order to deliver on the RED and AMBER issues investment will be necessary, particularly regarding workforce. The Midwifery workforce recommendations are being finalised for submission to the Quality & Safety Committee by August 2022.

5. RECOMMENDATION

Quality & Safety Committee is asked to :

- Note the initial assessment against the assurance framework for maternity services which was submitted to WG on 27th May 2022.
- Agree the baseline risk assessments for the red RAG rated areas, and the short-term actions associated with them.
- Agree to receive an update following the national meeting on 7th July.
- Note that the action plan will be further developed following the meeting on 7th July.
- 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.

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 maternity assurance framework are unknown at this time. The timetable for national work supported by the Welsh Government, maternity and neonatal network and the developing maternity and neonatal safety programme may bring additional resource from central government funding. Work includes the Birthrate+Cymru project and Maternity Digital Cymru project.

Legal Implications (including equality and diversity assessment)

Not required

Staffing Implications

The health board maternity service is undertaking a workforce review to ensure safe and effective midwifery care for future service delivery. The work will align with the National Timetable of events and workforce review across the seven health boards in Wales.

The Obstetric, Anaesthetic and Neonatal staffing requirement is set out in the benchmark document to be in line with national professional standards.

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	1. Maternity and Neonatal Network Assurance Document 2. CNO letter received into Health Board 13th May 2022 3. Completed exception reporting for RED and AMBER self assessment